Ryan White Part A
Cleveland TGA

Cuyahoga County Board of Health

Cleveland TGA

Ryan White Part A Program

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Introduction

Statement of Purpose

The Cuyahoga County Board of Health has developed this manual as a guide for the effective implementation of the Greater Cleveland Transitional Grant Area (TGA) Ryan White Part A Program grant management and service delivery business processes. This manual should be used as a point of reference for Ryan White Part A Program grantee staff and Part A funded contractors/service providers.

This manual contains a broad range of information to assist grantee staff and contractors/service providers in day to day management of program and reporting requirements. This manual is meant to be a "living document" and will continue to be updated as legislative and program changes occur.

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Application and Use of this Manual

This policies and procedures manual has been designed as a resource tool for the administration and implementation of the Ryan White Part A Program. The manual has been organized by types of business transactions and requirements. Each policy and/or procedure contains the following:

- Policy Statement: provides a background, description and intent of the policy
- Procedures: action items required for the contractor/service provider to be compliant with established policy
- Authority/Oversight: origin of the policy and the entity that provides oversight for implementation of the policy/procedure
- Published Date: the effective date of the policy/procedure, including any revision date(s)

The development of Ryan White Part A policies and procedures is an open and ongoing process requiring updates and/or changes that may result from legislative, administrative, fiscal, programmatic and/or continuous quality improvement changes. Updates and/or revisions to these policies and procedures will be provided by the Part A grantee's office in the form of a "Policy and Procedure Revision Form" that will identify the policy/procedure being updated or changed, the effective date, and the updates or changes to the policy/procedure. It is expected that updated/revised policies and procedures will be shared with appropriate staff responsible for implementing the policy/procedure.

Questions regarding the implementation of the policies and procedures in this manual should be directed to the Ryan White Part A Program Supervisor. Any exemption sought to these policies/procedures must be approved by the Part A Program Supervisor or Part A Project Director.

Definitions

Policies: the rules or guidelines by which an agency operates. They may be general or specific but always reflect the philosophy, mission and goals of the agency. Policies are generally approved by the agency's leadership and implemented by management. They define operations such as staff organization, services, business hours, and conditions for business transactions. Policies may, among other functions, set criteria for eligibility to receive services, establish the agency's commitment to confidentiality of protected or sensitive information, and/or processes for managing and monitoring of contracts.

Procedures: the methods or sets of instructions by which policies are carried out. Procedures provide specific steps for accomplishing required tasks, handling information, and making service delivery decisions.

Constructive feedback related to this manual is welcomed and will be thoughtfully considered by Part A grantee staff as updates and revisions are being made. All comments, suggestions or feedback should be forwarded to the Part A program supervisor at: mrodrigo@ccbh.net.

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Overview

I. RYAN WHITE PROGRAM

A. History

The Ryan White Program was established in 1990 to improve the quality and availability of care for limited-income, uninsured, and underinsured individuals and families affected by HIV/AIDS. The program is named after an Indiana teenaged boy whose courageous struggle with HIV and against AIDS-related discrimination helped educate the nation.

The AIDS epidemic began in the early 1980s and has had the greatest impact on populations at high risk for poverty and with limited or no access to the health care system. Persons living with HIV/AIDS (PLWHA) tend to be poorer than the general population, and clients accessing Ryan White Program services tend to represent the poorest of the poor since they are more likely to have limited or no source of public or private payment for services.

B. Ryan White Care Act Legislation

In August 2009 the U.S. Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to improve the quality and availability of health care services for low-income, uninsured, and underinsured PLWHA. The legislation has been reauthorized four times since its enactment, with the most recent reauthorization occurring in 2009. The Ryan White Treatment Extension Act expired on September 30, 2013, but funding has been extended in subsequent years through appropriations bills. This critical federal funding allows over 500,000 PLWHA receive necessary health care each year.

C. Ryan White Program Extensions Act

1. **Language:**
   The Ryan White HIV/AIDS Treatment Extension Act of 2009 provides the federal HIV/AIDS programs in the Public Health Services (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic. In 2009 the Act extended the manner in which Ryan White funds can be used, with a continued emphasis on providing life-saving and life-extending services for persons living with HIV/AIDS across the country.

2. **Key Points of the 2009 Reauthorization:**

   - Minority AIDS Initiative (MAI) funds under Parts A and B will be distributed according to a formula based on the distribution of populations disproportionately impacted by HIV/AIDS.

- Continued issuance of Part A funds to Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). For TGAs that lose their eligibility status, the state in which the TGA is located will receive incremental transfers of funding for three years.

- A new requirement to determine not only the size and demographics of the diagnosed HIV/AIDS population, but also those who are infected but unaware of their HIV status. One-third of Part A supplemental grant funds are to be based on the EMA's/TGA's ability to demonstrate its success in identifying infected individuals unaware of their status and linking them to care.

- Part A and Part B grantees must develop comprehensive plans that include a strategy for identifying infected individuals who are not aware of their status and linking them to appropriate health care services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.

- The allowance for unobligated balances to be carried over into the next grant year increased from 2% to 5% of formula funds.

D. Guiding Principles of the 2009 Reauthorization of the Ryan White Program

The Ryan White Part A Program addresses the health needs of PLWHA by funding primary health care services and supportive services that enhance access to and retention in care. The following principles were crafted by the HIV/AIDS Bureau (HAB) to guide all funded Ryan White programs in implementing CARE Act provisions and addressing emerging challenges in HIV/AIDS care:

1. **Revise Care Systems to Meet Emerging Needs:**
   The Ryan White Program stresses the role of local planning and decision making with broad community involvement to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems to meet the needs of emerging communities and populations. A priority focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PLWHA who know their HIV status but are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services.

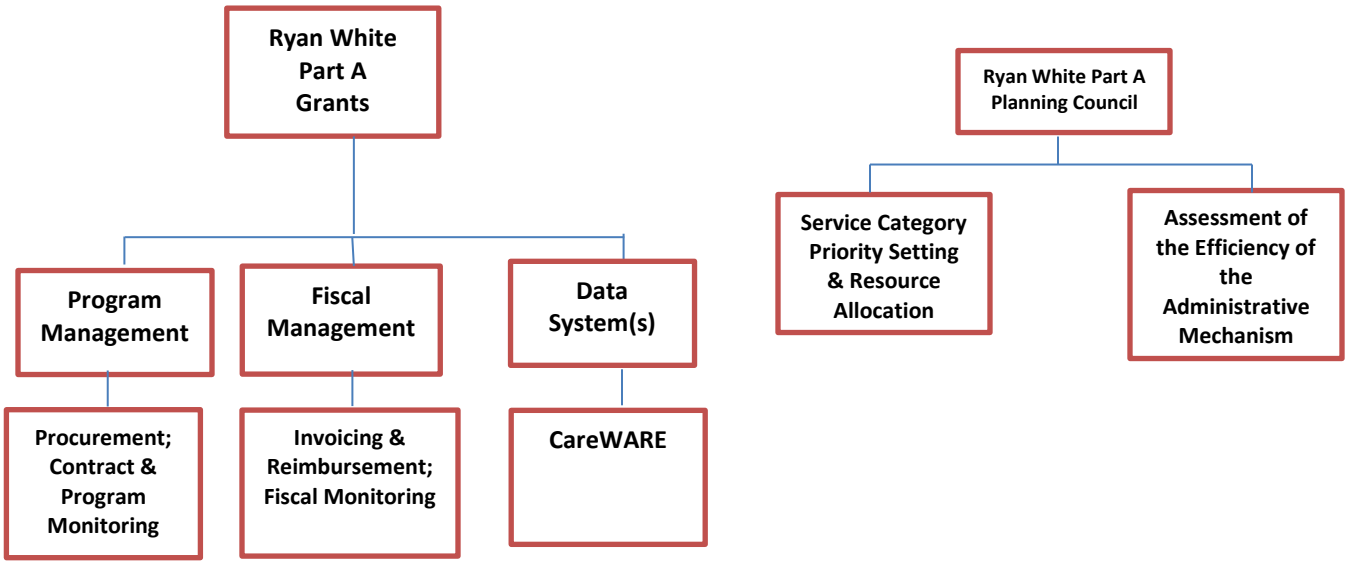
2. **Ensure Access to Quality HIV/AIDS Care:**
   The quality of HIV/AIDS medical care, including combination antiretroviral therapies and prophylaxis for opportunistic infections, can make a critical difference in the lives of PLWHA. Programs should employ quality management strategies to ensure that available treatments are accessible and delivered according to established and current HIV-related treatment guidelines.

3. **Coordinate Services with Other Health Care Delivery Systems:**
   Ryan White funded services are meant to fill gaps in care, which requires coordination across Ryan White Parts A – F and other federal, state and local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS related services within managed care plans, particularly Medicaid Managed Care.

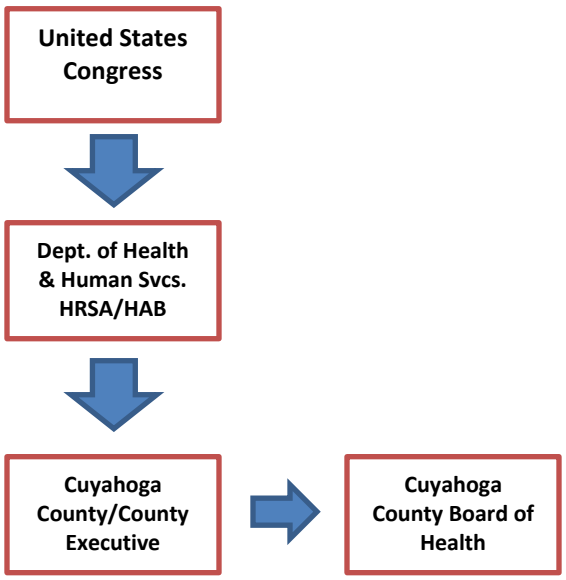
4. **Evaluate the Impact of Funds and Make Needed Improvements:**
   Federal policy and funding decisions are increasingly determined by outcomes. Programs need to demonstrate the impact of Ryan White funds on improving access to quality care and treatment along with areas of continued need. Programs also need to have quality assurance and evaluation mechanisms in place that assess the effects of Ryan White resources on the health outcomes PLWHA served.

E. Part A Structure

1. Program Management Structure



2. Funding Structure



The Greater Cleveland Transitional Grant Area (TGA) Ryan White Part A Grant Program is funded directly by the U.S. Department of Health and Human Services, Health Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB). The Ryan White Part A Program works in collaboration with the Cuyahoga Regional HIV/AIDS Health Services Planning Council to guide the prioritization of and resource allocation to Part A funded services. Services are provided through a network of contracted providers to support a full continuum of care.

3. Cleveland TGA Planning Council

Cuyahoga Regional HIV Health Services Ryan White Planning Council represents the Transitional Grant Area (TGA) that includes the following counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, and Medina.

The mission of the Planning Council is to plan for the comprehensive delivery of HIV/AIDS services and allocation of resources for the TGA. The goal of the Planning Council is to identify HIV positive individuals, see that they are linked into care, stay in care and improve health outcomes.

The Planning Council consists of a maximum of thirty-five (35) members, at least 33% of which are persons living with HIV/AIDS. Members are appointed by the Cuyahoga County Executive and Mayor of the City of Cleveland. Council members identify and rank service priorities and determine funding allocations based on needs assessment data gathered from each local jurisdiction in the TGA and other relevant data.

Planning Council meetings take place the third Wednesday of each month from 5:30-7:00 p.m. Please see the meeting notices (posted on www.ccbh.net) for location. All meetings are open to the public.

The Cleveland TGA Planning Council also has five subcommittee groups:

4. **Executive Committee:** Members shall work with the grantee agency to review monthly fiscal reporting data, review contract status data, establish the granting time lines, and monitor compliance with funding requirements.
5. **Membership, Retention, and Marketing:** Members will provide oversight and maintenance of the Planning Council membership outreach efforts to promote increased awareness and utilization of prioritized services for people living with HIV and AIDS.
6. **Strategy & Finance:** Members shall be responsible for oversight of the direct services allocations and expenditures, resource allocation and reallocation according to priorities set by the Planning Council and spending trends. This committee will also ensure the development of an ongoing process to evaluate and identify unmet service needs, which are eligible for funding through the Part A Program.
7. **Community Liaison Committee (CLC):** Members include community members who seek to improve Ryan White services by informing the Planning Council of their ideas, experiences and vision in order to improve the coordination of Ryan White services within the TGA and increase the health outcomes of PLWHA.
8. **Quality Improvement:** This committee oversees all quality activities of the Ryan White Part A Program. The QI Committee ensures that services funded by Part A meet or exceed established HIV clinical standards and Public Health Services guidelines.

Priority Setting and Resource Allocation (PSRA) Information

Led overall by the Planning Council's Strategy & Finance (S&F) Committee; and the PC's Quality Improvement (QI) Committee for directive development, the FY2020 PSRA process, again included multiple activities over several months. These activities included:

1. A detailed PSRA work plan and schedule of activities.
2. Updating and approving a written description of the PSRA Process.
3. A Formal written data request to the Part A Recipient for a wide range of data.
4. PSRA Refresher Training.
5. A series of discussions related to directive development, resulting in three new directives for 2020.
6. A series of data presentations (epi, client utilization & spending, needs assessment findings that identify core funding gaps, and PLWH feedback from expanded mini-education outreach sessions and a Consumer Forum.
7. Establishing service priorities and developing directives to improve the TGA's system of care.
8. Allocation of funding to needed HIV-related primary health care and support services, and;
9. Voting and approving the PSRA final decisions by Executive Committee members and the full PC.

In conducting the 2020 PSRA process, the PC continued to incorporated improvements that ranged from refining an improved service priority ranking model; to broader consumer input and data collection initiatives; a consumer forum; the review of a broad array of data, including epidemiology, utilization & spending, review of other HIV-related funding sources in the Cleveland TGA, including other RW Parts and Housing Opportunities for People with AIDS (HOPWA) utilization and spending. PSRA improvements for the 2020 Grant Year included:

> *Further refining its service priority ranking and scoring model for determining priorities* – for the 2020 PSRA process, the PC expanded data collected to support each criterion in its model. Data that included other primarily public funding sources of HIV-related health care and support services within the TGA; expanded PLWH feedback data from additional mini-education sessions, consumer forums and needs assessment findings from 2013-2018; as well as identified service gaps. Further refining the model improved PC decision-making and provided greater rationale to support how the service are prioritized. It further reduced subjectivity and provided a more systematic method for evaluating the importance of a service.
>
> The Community Liaison Committee expanded *"Mini-Education Outreach Sessions,"* the consumer initiative that began with the 2019 Grant Year to increase consumer awareness of RW funded services and collect data in the process through a series of facilitated discussions at Part A-funded Support Groups in the TGA. The expanded

sessions solicited broader feedback on access to and barriers to RW services. The data collected was an added contribution to the ranking of services priorities as well as allocation decisions and provided important weight for PLWH priorities.

***Determining Priorities*:** The PC's S&F Committee led the priority setting by reviewing data from February to May 2019 for each criterion in the PSRA model for every service. To decide priorities, criteria used in the Cleveland TGA PSRA Model was:

1) *Payer of Last Resort* (weight factor 15%) – Is RW the ***only*** payer source available to consumer in the TGA for the service. The S&F committee considered whether there were other funding sources, the number of other sources and the amount of funding available for each RW allowable service category in the Cleveland TGA in determining how the service would be prioritized.

2) *Access/Maintenance in Care* (weight factor 35%) - Does the category promote access or maintenance in primary medical care? The committee considered and debated the role of each service category in linking PLWH to care or helping maintain them in care, or whether the service has a correlation between linkage and/or retention in care.

3) *Specific Gaps/Emerging Need* (weight factor 25%) - Does the service address a specific service gap or service need? Does it address a newly identified or projected future need? The committee reviewed needs assessment findings over several years as well as feedback from the Grantee, based on input from the Part A provider network in the Cleveland TGA, to determine whether the service addressed a specific gap in service delivery or an emerging need for PLWH.

4) *Consumer Priority* (weight factor 25%) – Has the service category been specifically identified as a priority by PLWH through needs assessment data and/or other data as important and/or needing additional funding? The committee reviewed needs assessments, consumer feedback from Community Forums from 2012-2017 and the feedback from the newly implemented "Mini-Education Sessions."

5) *Allocated a Score to each service category from 1- 8* – On a scale of 1 (poor/limited value) to 8 (high value). Each criterion within the service category was assigned a score, then multiplied by the weight factor, then each criterion was added to tally the recommended rank. The following is a sample from the 2020 Service Priority Ranking process using Part A, Outpatient Ambulatory Health Service category in the Cleveland TGA.

2020 Service Priority Ranking Sample

Outpatient Ambulatory Health Services					
Service Category	**Payer of Last Resort**	**Access to Care/Maintenance In Care**	**Specific Gaps/Needs**	**Consumer Priority**	**Total**
Criteria Factor	(x 15%)	(x 35%)	(x 25%)	(x 25%)	Notes Recommendations
Scale	6	8	8	8	7.7
Medical Care (OAHS)	Other funding sources: **Part A**-7 **Part C**-2 **Part D**-1 **Medicaid**	Essential for Access to HIV Care and Maintenance in Care, Retention in Care, ART and Viral Suppression	Identified as an essential service for PLWHA	Consumers ranked OAHS 1st in overall priority in 2018.	Overall spending in 2018 totaled $974,218 or 98% of its allocation amount. 6-yr. Utilization Patterns: **FY13** – 2,252 **FY14** – 1,724 **FY15** – 1,202 **FY16** – 1,999 **FY 17** – 2,045 **FY 18** – 2,057

Resource Allocation: The PC conducted its resources allocation conference on June 19, 2019 for the FY2020-2021 RWHAP program year. During the allocation conference, recaps of a range of data reviewed over the course of the PSRA schedule were presented. This included the most recent epidemiology of the TGA, utilization and spending trends from 2013-2018, and other funding sources that included Medicaid, other Ryan White Parts, HOPWA as well as available local private/non-profit HIV-related services and spending. The PC utilized a service usage cost pattern table reflecting RWHAP utilization and spending trends to assist with allocating funds for each service category. The table included data that represented each funded service, total cost per service category, total number of clients served, average expenditure per client, and the definition for each funded service including how the service is funded *(i.e. Full-Time Equivalent, unit based funded services, etc.)*. To determine allocations, the PC considered the service category ranking in order of importance, whether other non-RW funds were available in the TGA, consumer feedback and current utilization & spending patterns for each service.

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Eligibility Policy

Policy Number: 100.01

Effective: April 1, 2017

Previous Version: March 15, 2015

III. Introduction

This policy outlines the roles, responsibilities, and requirements for establishing and maintaining Ryan White Part A Program (program) client eligibility in the Cleveland TGA.

The program has established standard eligibility forms and uniform documentation requirements to increase the consistency of applicant eligibility-related experiences across agencies, while reducing duplicative applicant and staff efforts.

Throughout, emphasis is placed on the importance of ensuring that Ryan White is the "payer of last resort", as required under federal law, through documentation of ongoing agency efforts to identify and vigorously pursue client utilization of other third party payers, maximizing the impact of limited program resources.

IV. Eligibility Criteria

Applicants must provide documents establishing the following:

1. HIV/AIDS diagnosis;

2. Cleveland TGA residency- Currently living in one of these Ohio counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain or Medina;

3. Low-Income- A MAGI-based monthly household income at or below 500% of the current Federal Poverty

4. Uninsured or Underinsured- Agencies must explore and eliminate all other possible sources of third party payment before using Ryan White funds to pay for a service(s). Clients with insurance or access to insurance must submit documentation of coverage.

V. General Policy Requirements

Agencies must establish and implement written policies and procedures which comply with this policy, the National Monitoring Standards; HRSA/HAB regulations, HAB policy notices and letters; contract terms; and all other applicable federal, state, and local statutes and requirements.

VI. Client Insurance Eligibility and Enrollment

Agencies are expected to make every reasonable effort to ensure uninsured clients are screened for eligibility in all possible public and private insurance options.

Agencies must have written policies and protocols in place to ensure they are vigorously pursuing client enrollment in health care options. They must inform uninsured clients of the consequences of not enrolling in a public or private health insurance option. They must have a written protocol outlining their required process for the pursuit of enrollment in health care coverage, including how the process will be uniformly documented and easily accessible to monitors. Agencies must ensure that eligibility protocols are uniformly and consistently implemented.

If after extensive documented agency efforts, a client remains un-enrolled in healthcare coverage, the client may be served by the program. Ryan White remains the payer of last resort, and agencies are expected to maximize all resources and health dollars in order to serve the most clients.

VII. Personnel Requirements

Agency staff conducting eligibility must ensure that clients are aware of and access all other public and private third party payers for which they are eligible before accessing Ryan White funds. In order to ensure accurate Ryan White eligibility determinations, staff conducting eligibility assessments, must:

1. Have strong administrative, interviewing, and communication skills;

2. Communicate effectively, respectfully, and sensitively with clients from diverse cultural and demographic backgrounds and have the ability to assess client linguistic needs;

3. Be knowledgeable about Ryan White Part A eligibility requirements, policies and procedures;

4. Have knowledge and expertise regarding the Affordable Care Act and the key components being implemented in Ohio; be knowledgeable about Ohio's Medicaid expansion for low-income adults; and understand the eligibility and enrollment processes and requirements of both programs, as well as other public and private third party payment sources.

VIII. Electronic Eligibility

All eligibility applications, forms, and verification documents must be uploaded to CAREWare. Each document must be clearly marked with the date it was obtained or completed. All eligibility information must be uploaded and named according to naming procedures.

IX. Agency Responsibility

To reduce the burden on applicants, eligibility documents should be uploaded into CAREWare in a timely fashion. Contractually, the responsibility for documenting the provision of allowable services to eligible clients rests with the agency providing services. Every agency providing services must ensure a client's eligibility is unexpired and documented in CAREWare at the time service is provided.

Recertification and Documentation Schedule

In order to establish and maintain continuous eligibility, an applicant must comply with the following recertification and documentation schedule:

	Initial Eligibility	**Semi-Annual Eligibility** No Changes	**Annual Eligibility,** or Semi-Annual Recertification- With Changes
HIV Status	**Documentation required**	*No Documentation*	*No documentation*
Residency	**Documentation required**	*No documentation*	**Documentation required**
Income	**Documentation required**	*No documentation*	**Documentation required**
Insurance Status	**Documentation Required**- coverage, coverage denial, or of agency's ongoing vigorous efforts to enroll client required.	*No documentation*	**Documentation Required**- coverage, coverage denial, or of agency's ongoing vigorous efforts to enroll client required.

X. Initial Eligibility Determination

A new or returning applicant seeking program eligibility meets face-to-face with a member of the agency's eligibility staff to complete an Eligibility Application.

Eligibility is established when all verification and documentation criteria are met. See Section VIII for an overview of initial eligibility documentation requirements. These requirements are outlined in greater detail in the Eligibility Application and supporting documents. The applicant's self-report of initial eligibility criteria is not sufficient documentation.

Ryan White is the payer of last resort. Agency eligibility staff must screen the client for eligibility for other potential third-party payers and assist the client in completing related applications, as needed. Documentation of these efforts and copies of the third-party applications must be maintained in the client file.

XI. Semi-Annual Recertification

In order to maintain eligibility, at least every six months a client must meet face-to-face with agency eligibility staff to complete semi-annual recertification. At that time, if a client reports no changes to eligibility criteria, no documentation is required and an Eligibility Recertification- No Changes form is completed.

If a client reports any changes to eligibility criteria, an Eligibility Application must be completed . See Section VIII for an overview of related documentation requirements. It is not acceptable for a client to self-report eligibility criteria when an Eligibility Application is completed at semi-annual recertification.

Ryan White is the payer of last resort. At semi-annual recertification, agency eligibility staff must screen the client

for eligibility for other potential third-party payers and assist the client in completing related applications, as needed. Documentation of these efforts and copies of the third-party applications must be maintained in the client file.

XII. Annual Recertification

In order to maintain eligibility, a client must complete annual recertification at least once every twelve months. During annual recertification, a client meets face-to-face with agency eligibility staff to complete an Eligibility Application.

See Section VIII for an overview of Annual Recertification documentation requirements. These requirements are outlined in greater detail in the Eligibility Application and supporting documents. At annual recertification, it is not acceptable for a client to self-report eligibility criteria.

Ryan White is the payer of last resort. At annual recertification, agency eligibility staff must screen the client for eligibility for other potential third-party payers and assist the client in completing related applications, as needed. Documentation of these efforts and copies of the third-party applications must be maintained in the client file.

Standards of Care

Service standards of care (SOC) outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) service provider follows when implementing a specific service category. The purpose of service SOC are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service SOC establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction. They set a benchmark by which services are monitored, and subrecipient contracts are developed. Each funded service category must have a unique set of service standards. There may be some overlap of service SOC among two or more service categories (e.g., medical case management and non-medical case management may both assist with enrolling clients in insurance assistance programs).

Please reference the individual Standards of Care listed in the Appendix for detailed information pertaining to each funded service category.

Data to Care

Data to Care (D2C) is a public health strategy that uses HIV surveillance data and other data sources to identify persons with HIV who are not in care, link those who are not in care to appropriate medical and social services, and ultimately support the HIV Care Continuum. The CCBH Part A program is the lead for D2C activities in the Cleveland TGA. The program utilizes a hybrid model approach for D2C. Individuals on the Not In Care (NIC) list last seen by a Part A-funded medical provider will be contacted by that provider to get them back into care. Individuals on the NIC list not seen by a Part A agency or never seen at all by a provider will be contacted by CCBH in an attempt to link them to care. The NIC list is provided to CCBH by the Ohio Department of Health twice a year. Below is the protocol for D2C activities in the Cleveland TGA.

Please reference the Ryan White Part A Program Cleveland TGA Data to Care Manual on Page 107 for more information.

CAREWare

CAREWare is free, HRSA sponsored software used to manage and monitor HIV clinical and supportive care as well as produce federally required service reports. CAREWare is updated regularly to be compliant with HAB reporting requirements. The software is scalable and can be customized to meet local needs.

CAREWare was originally released at a Grantee (Recipient) Meeting in 2000. Usage has increased steadily each year and today over 800 Ryan White-funded agencies in 48 States, Puerto Rico, and the U.S. Virgin Islands use the software to manage their HIV/AIDS information.

The Cleveland TGA began using the CAREWare data collection system in 2011. The Cleveland TGA CAREWare database is hosted on our own secure server and meets all federal, state and local privacy standards. All Cleveland TGA sub-recipients are required to enter data using the CAREWare system. Due to changes in HRSA/HAB reporting requirements and availability of new features or modules, the Cleveland TGA CAREWare software is typically updated every 6-8 months. Only clients that meet out TGA's eligibility requirements should be entered into the Cleveland TGA's CAREWare system.

Please reference the Ryan White Part A Program Cleveland TGA CAREWare 6.0 Manual on Page 124 for more information on how CAREWare is utilized for data reporting and collection.

General Program Requirements

The Sub-Recipients may not use funds to make cash payments to intended clients of core medical or supportive services. This prohibition includes cash incentives and cash intended as payment for RWHAP services. Where direct provision of the service is not possible or effective any alternative method of payment for services must be submitted to the Cuyahoga County Board of Health for approval. Alternative methods of payment cannot be exchanged for cash or used for anything other than allowable goods or services.

The parties expressly agree that in the event services commence on and after the effective date of this agreement (as set forth in Section 1) but prior to the date of execution of the agreement, the parties expressly authorize payment for such services with the understanding that no such payment will be made by the Board until after receipt of a fully executed agreement.

Sub-Recipient understands and agrees that it will not be paid for services provided prior to the Effective Date of this Agreement. If, pursuant to a later audit by the grant funder, the funder rejects any payment made by the Board to the Sub-Recipient that is deemed by the funder to be in violation of the terms of this agreement, any amount deemed improperly paid to the Sub-Recipient shall be promptly reimbursed by the Sub-Recipient to the Board or, alternatively, the Board may use the amount improperly paid as a set off against future payments by the Board to the Sub-Recipient.

Payment will be limited to those consumers eligible for such service and only for services as defined by The Ryan White Treatment Extension Act of 2009 (RW Act), The Cuyahoga Regional HIV Services Planning Council and this Agreement as authorized by the Board.

The Sub-Recipient shall maintain original documentation, such as time sheets, payroll journals, tax records, travel vouchers, vendor invoices, lease agreements, canceled checks, logs and receipts in a manner that will expedite an on-site fiscal monitoring of program costs.

If the Sub-Recipient is contracting multiple service categories, the total dollar amounts reimbursable for each service category listed separately in Exhibit B are intended specifically for those individual service categories. Award amounts of up to twenty percent (20%) for one service category may be transferred by the Sub-Recipient to another service category within the contract only with the written approval from the Board and in the final month of the contract.

The sub-recipient must adhere to the core service category expenditures in order to be reimbursed fully for the support category expenditures if and only if the grantee is in jeopardy of exceeding the federal mandated maximum award for support service categories.

This Agreement is conditional upon the availability of federal, state, or local grant funds that are appropriated or allocated for payment of this Agreement. If funds are not allocated and available for the continuance of the function performed by the Sub-Recipient hereunder, the products or services directly involved in the performance of that function may be terminated by the Board. The Board will notify the Sub-Recipient at the earliest possible time of any products or services that will or may be affected by a shortage of funds. No penalty shall accrue to the Board in the event this provision is exercised, and the Board shall not be obligated or liable for any future

payments due or for any damages as a result of termination under this section. Should the Health Resources Services Administration add additional conditions of award the Board will amend the contract language.

NO ASSIGNMENT, TRANSFER, OR SUBCONTRACT

In performing the services specified under the terms of this Agreement, the Sub-Recipient shall not assign, transfer, delegate any of the work or services, nor subcontract the work out to any other entity, nor shall any subcontractor commence performance of any part of the work or services included in this Agreement without obtaining the prior written consent of the Board.

INDEPENDENT CONTRACTOR

No Sub-Recipient, employment, joint venture or partnership has been or will be created between the parties hereto pursuant to the terms and conditions of this agreement. Inasmuch as the Board is interested in the Sub-Recipient's end product, the Board does not control the manner in which the Sub-Recipient performs this contract. The Board is not liable for the workers' compensation or unemployment compensation payments required by Chapters 4123 and 4141 of the Ohio Revised Code, respectively. In addition, the Sub-Recipient assumes responsibility for all tax liabilities that result from compensation paid to the Sub-Recipient by the Board. The Board will report any payment made under this contract to the Internal Revenue Service on Form 1099.

No provision contained in this contract shall be construed as entitling the Sub-Recipient to participate in hospital plans, medical plans, sick leave benefits, vacation, and other benefits available to employees of the Board or to become a member of the Public Employees Retirement System (Chapter 145 of the Ohio Revised Code.).

INDEMNIFICATION

The Sub-Recipient agrees to indemnify and hold the Board, all of its departments, agents and employees harmless from any and all liabilities, obligations, claims, costs and expenses

caused by or resulting from the Sub-Recipient's performance or nonperformance of the obligations or activities contemplated by this Agreement.

The Sub-Recipient shall reimburse the Board, all of its departments, agents and employees for any judgments or liens which may be obtained against the Board, all of its departments, agents and employees resulting from the Sub-Recipient's performance or non-performance of the obligations or activities contemplated by this Agreement, including judgments or liens for infringements of intellectual property rights of third parties.

The Sub-Recipient agrees to defend the Board, all of its departments, agents and employees against any such claims, legal actions, or liens if called upon by the Board to do so. The Sub-Recipient acknowledges that this Agreement involves the use of public funds and as such is subject to audit by public agencies granting funds to the Board. The Sub-Recipient shall fully indemnify and repay the Board for any reimbursed costs of the Sub-Recipient which are subsequently disallowed by the funding public agencies and which must be refunded by the Board to such agencies.

INSURANCE

Contractor will at all times during the Term and for a period of three (3) years after the expiration or termination of this Agreement, at its own cost and expense, carry, maintain, and have in force, covering all matters, claims, and losses associated with this Agreement and the performance of the Services, the minimum insurance and coverage limits set forth in Exhibit E, and Contractor will comply with all other requirements set forth in Exhibit E.

UNRESOLVED FINDING FOR RECOVERY

Ohio Revised Code Section 9.24 prohibits the award of a contract to any party against whom the Auditor of the State has issued a finding for recovery, if the finding for recovery is "unresolved" at the time of the award. By executing this contract, the Contractor warrants that it is not now, and will not become subject to an "unresolved" finding for recovery under the Ohio revised Section 9.24 without notifying the Board of Health of such finding. A Finding for Recovery will result in immediate termination of this Agreement.

PROHIBITED AFFILIATIONS; SUSPENSION AND DEBARMENT

Contractor certifies, represents, and warrants that (a) none of the Contractor Parties is suspended and/or debarred from doing business with state and/or federal government programs and (b) all Contractor Parties have been cleared of debarment from the following websites, prior to executing this contract and/or providing the services described herein to the Board:

* http://www.sam.gov/
* http://oig.hhs.gov/fraud/exclusions.asp

Contractor will check these websites on a monthly basis during the Term with regard to the Contractor Parties. If Contractor is notified of or otherwise becomes aware of a suspension and/or debarment during the Term, Contractor will notify the Board of such suspension and/or debarment as soon as practicable, but in no event later than five (5) days after Contractor becomes aware of such occurrence.

COMPLIANCE WITH CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS

Congress has enacted Pub. L. 112-239, January 2, 2013, which mandates a pilot program entitled, "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections." Pursuant to this law, the Sub-Recipient shall certify that it is in compliance with this law which certification shall verify that the Sub-Recipient did require all of its grantees, their sub-grantees and subcontractors to:

a) Inform their employees working on any Federal award they are subject to the whistleblower rights and remedies of the pilot program;

b) Inform their employees in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and,

c) Contractors and grantees will include such requirements in any agreement made with a subcontractor or sub-grantee.

ACKNOWLEDGEMENT OF FEDERAL FUNDING AND DISCLAIMER

The Sub-Recipient shall use the following acknowledgement and disclaimer on all products produced with HRSA funds:

"This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and title for grant amount (specify grant number, title, total award amount and percentage financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

OWNERSHIP COPYRIGHT

The Sub-Recipient agrees to acknowledge the financial support of the Board on any publications, promotional brochures, media releases or other publicity materials produced with the resources from this agreement. That acknowledgement should be displayed in a prominent location and include, at a minimum, the Board logo.

Printing, dissemination, and/or publication of any material developed under this Agreement must be provided to the Board and be pre-approved by the Board.

Any item produced under this agreement with funds provided under this Agreement, including any documents, data, photographs and negatives, electronic reports/records, or other media, is the property of the Board, which has an unrestricted right to reproduce, distribute, modify, maintain and use the deliverables. The Sub-Recipient will not obtain copyright, patent, or other proprietary protection

for the deliverables. The Sub-Recipient will not include in any deliverable any copyrighted matter in the manner proved in this agreement. The Sub-Recipient agrees the deliverable will be made freely available to the general public unless the Sub-Recipient determines pursuant to state or federal laws, that such materials are confidential.

CRIMINAL BACKGROUND CHECKS

Whenever applicable, the Sub-Recipient shall conduct background checks on all employees in direct service positions under this Agreement in accordance with applicable requirements so as to not knowingly employ staff who have been convicted or plead guilty to any of the crimes specified in ORC §3319.39(B) or other section of the ORC applicable to the Sub-Recipient. Failure to conduct such background checks may result in termination of this Agreement.

ANTI-KICKBACK STATUTE

The Sub-Recipient shall comply with the requirements of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 13207b(b).

STAFF CHANGES

Changes of Sub-Recipient staff supported in whole or in part by funds awarded through this Agreement, require prior written approval of the Board. If prior written approval is not obtained, related expenses may not be reimbursed.

SALARY LIMITATION

The Sub-Recipient shall not use funds awarded under this contract to pay the salary of an individual at a rate in excess the Executive Level II salary of the Federal Executive Pay scale, as required under the Consolidated Appropriations Act, 2012 (P.L. 112-74), December 23, 2011, which limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements.

UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS

Agencies must comply with all applicable provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements 2 CFR 200 as codified by HHS at 45 CFR Part 75 including submit audits if required to the Federal Audit Clearinghouse Bureau of the Census.

CERTIFICATION OF CLIENT ELIGIBILITY

It is the responsibility of the Sub-Recipient to determine and document client eligibility status in CAREWare and as outlined in the Ryan White Part A- Cleveland TGA Eligibility Policy as well as RWHAP Policy 13-02. Agencies may not provide Ryan White services under presumptive eligibility; eligibility must be confirmed prior to enrollment/recertification. If a client is eligible for other third party reimbursement, it is the responsibility of the Sub-Recipient to bill the appropriate third party for services.

In any grant-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage.

By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage.

By statute, program funds may not be used for any item or service for which payment has been made or can reasonably be expected to be made by another payment source. Agencies must vigorously pursue client eligibility for other funding sources and third-party payers to extend finite grant resources to new clients and/or needed services. The Sub-Recipient shall document these enrollment efforts in a manner prescribed by the Board to ensure that the program only serves eligible clients and that the Ryan White Part A – Cleveland TGA is the payer of last resort.

PROGRAM PERFORMANCE REPORTING

The Sub-Recipient agrees to provide to the Board brief, periodic progress reports, as requested by the Board. Reports will to be relative to the effective operation of the program. The Sub-Recipient shall ensure accountability for the services identified in this contract by submitting service and fiscal reports.

A. Fiscal Reports are required in the form of monthly invoices detailing the allowable billable services performed during the previous calendar month as outlined in Section 3 above. Site visits will be conducted to verify that the services billed were performed and properly documented and comply with Part A service definitions.

B. Semi-Annual Program Reports are required for each funded service.

C. Annual Administrative Reports and the Ryan White HIV/AIDS Program Services Report (RSR) are required by HHS/HRSA/HAB. The format for the Annual Administrative Reports will be provided to the Sub-Recipient by the Board with instructions on completion. All RSR data will be collected through CAREWare. It is expected that sub-recipients collect and clean the client level service data of all Ryan White Part A eligible and eligible scope clients monthly.

D. Other additional information may be requested at any time by the Board.

Failure by the Sub-Recipient to produce timely and adequate reports will impact the Sub-Recipient's funding during the current contract period, as well as its eligibility for consideration for funding in subsequent years.

DATA SHARING AGREEMENTS AND SAFEGUARDING OF CLIENT RECORDS

Sub-Recipient agrees to adhere to the following terms and conditions:

A. The Sub-Recipient agrees that the use or disclosure by any party of any information concerning service recipients for any purpose not directly related with the administration of the Board or Sub-Recipient's responsibilities with respect to purchased services is prohibited except upon the express written consent of the individual being served.

B. The Sub-Recipient agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA), all of its relevant provisions and amendments and administrative rules applicable thereto in relation to the delivery, recording and billing of client health care and other applicable related clinical social services reimbursed by RW Act funds.

C. If the Sub-Recipient is not a Covered Entity under HIPAA, the Sub-Recipient shall sign and comply with the terms of the Business Associate Agreement in the same or substantially similar for as in Exhibit C.

D. The Sub-Recipient will maintain and improve a shared system of protected health information and service utilization while observing all applicable laws and standards on privacy, confidentiality, and security.

E. The Sub-Recipient agrees to comply with all federal and state laws applicable to the Board and/or consumers of RW Act funded services concerning the confidentiality of consumers Personal Health Information (PHI), including but not limited to R.C. 5101.27(A) and related Ohio Administrative Code 5101:1-1-03. Violation of these laws may result in conviction for a misdemeanor of the first degree.

F. The Sub-Recipient, prior to gaining access to Protected Health Information (PHI), will ensure that all employees, independent contractors, and agents responsible for management of shared data will complete HIPAA privacy training.

G. The Sub-Recipient will enter client information into CAREWare, including Protected Health Information, in compliance with relevant state and federal law and assuming the information will be shared, accessed, or disclosed to other agencies contracted to provide services using Ryan White funds that have access to CAREWare for treatment, including coordination of care, or payment.

H. The Sub-Recipient will ensure client confidentiality requirements apply to all phases of the project.

I. The Sub-Recipient will use the Cuyahoga County Board of Health's Release of Information form for all clients served under the Cleveland Part A Transitional Grant Area (TGA).

ACCESS TO RECORDS

The Sub-Recipient shall retain, maintain and keep accessible all records relevant to this Agreement for a minimum of six (6) years, following Agreement termination, or full performance, or any longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Sub-Recipient shall maintain all financial records in accordance with generally accepted accounting principles. All other records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, the Sub-Recipient shall permit authorized representatives from the Board and HHS access to the records at reasonable times and places for purposes of inspection, audit, examination and copying.

PROGRAM POLICIES AND GUIDELINES

The Board reserves the right to add, delete, or modify program policies and implementation guidelines in order to administer the program efficiently and in compliance with the Ryan White Act, HRSA Guidelines, Ryan White Part A Manual, Ryan White National Monitoring Standards, all applicable HIV/AIDS Bureau Policy Notices and Program letters, all applicable Federal and State laws, Cleveland TGA Standards of Care, Cleveland TGA Service Definitions, documented unmet need and service gaps within the Cleveland TGA, and priority setting or resource allocation decisions made by the Planning Council. Planning Council is provided with aggregate summary reports of monitoring data by service category. The Sub-Recipient agrees to comply with all terms of RFP# 2016-08: *Ryan White HIV/AIDS Treatment Extension Act Part A Program A & Minority Aids Initiative*, issued by the Board on November 10, 2016. Planning Council is also provided with aggregate fiscal reports and other requested data so that appropriate funding allocations can be determined. However, by statute, Planning Council may not be involved in contract procurement, monitoring or any other aspect of routine grant administration. Sub-Recipient staff may not disclose to Planning Council, or individual Planning Council members, any information related to Sub-Recipient contractual and/or administrative issues related to this Agreement or the administration of this Agreement.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The Sub-Recipient shall adhere to the National Standards on Culturally and Linguistically Appropriate Services, and, as required by EO 13166, August 11, 2000, the Sub-Recipient shall provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services.

ANTI-DISCRIMINATION AND EQUAL EMPLOYMENT OPPORTUNITY

The Sub-Recipient agrees that in the employment of labor, skilled or unskilled, under this contract, there shall be no discrimination exercised against any person because of race, religion, national origin, sex, ancestry, age, disability, sexual orientation, or veteran status, and that violation thereof shall be deemed a material breach of said contract.

The Sub-Recipient shall comply with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

The Sub-Recipient shall comply with the Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in any program or activity receiving Federal financial assistance, and as supplemented by regulations codified at 45 CFR part 91

The Sub-Recipient shall comply with Title IX of the Education Amendments of 1972, 20 U.S.C. 1681, 1682, 1683, 1685, and 1686, which provides that no person in the United States will, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance, and as supplemented by regulations codified at 45 CFR part 86.

TRAFFICKING VICTIMS PROTECTION

The Sub-Recipient shall comply with the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104).

MANDATORY DISCLOSURES

Consistent with 45 CFR 75.113, sub recipients must disclose, in a timely manner, in writing to the Board and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG.

ACCESSIBILITY OF INFORMATION

The sub-recipient shall make all files, including captioning, audio descriptions, videos, tables, graphics/pictures, registration forms, presentations (both audio and video) or other types of proprietary format files – e.g., Adobe Portable Document Format (.pdf), Microsoft Office PowerPoint (.ppt) and Microsoft Excel (.xls), fully accessible to members of the public with disabilities. Technical and functional standards for accessibility are codified at 36 CFR Part 1194 and may be accessed through the Access Board's Web site at http://www.access-board.gov

340B PROGRAM COMPLIANCE

Consistent with Departmental guidance, HRSA recipients that purchase, are reimbursed or provide reimbursement to other entities for outpatient prescription drugs are expected to secure the best prices available for such products and to maximize results for the grantee organization and its patients. Eligible health care organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. The 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa/.

PARTICIPATIONAGREEMENT

All providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or receive a waiver from this requirement.

FUNDING EXCLUSIONS AND RESTRICTIONS

The funding exclusions and restrictions are found in Exhibit D, attached hereto and incorporated fully herein by reference.

GRIEVANCE PROCEDURE

The Sub-Recipient shall provide the Board with written notification of any concerns or complaints. Where a conflict cannot be resolved, the Sub-Recipient may initiate a grievance process which shall consist of mediation and, if necessary, binding arbitration. Notification should be sent as provided in Section 33 below.

NOTICES

All notices, invoices and correspondence which may be necessary or proper for either party shall be addressed as follows:

TO THE BOARD:

Cuyahoga County District Board of Health

Attention: Claire Boettler, RN, MPH

Director, Prevention and Wellness

5550 Venture Drive

Parma Ohio 44130

(216) 201-2001

TO THE SUB-RECIPIENT:

Name/Title

Address

City, State, Zip

Phone Number

Clinical Quality Management (CQM)

Ryan White Part A recipients are required to implement Clinical Quality Management activities. Specifically, the Ryan White Program legislation dictates that all recipients must: "establish a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections. [As applicable, recipients should] develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." In addition to legislative requirements, HRSA/HAB requires recipients to establish and implement a written Clinical Quality Management Plan to guide quality related activities in the local service area.

The overall mission of the Cleveland Transitional Grant Area Clinical Quality Management Program is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all HIV-infected individuals served by the TGA. Culturally and linguistically competent medical and social service provider's work collaboratively with administrative staff and consumers to create, implement, and maintain a dynamic program to facilitate receipt of comprehensive, state of the art, high quality care. This Clinical Quality Management Program aligns with the 2020 National HIV/AIDS Strategy goals, and adheres to established HIV clinical practice standards and Public Health Service guidelines in order to best address the needs of the Cleveland TGA community.

The vision of the TGA Clinical Quality Management Program is to improve and enhance the health and wellness of the population we serve. Through the work of the Clinical Quality Management Committee, the CQM Program aims to become a local resource for anyone wishing to improve the outcomes and support services of HIV health care for consumers, communities, and public health.

The Clinical Quality Management Program works towards meeting or exceeding HAB expectations to establish and maintain a clinical quality management program and alignment with the National HIV/AIDS Strategy 2020 (NHAS). The Clinical Quality Management Program includes documented accountability for all service provision, with quantitative performance measurement and capacity building for providers and consumers resulting in ongoing and meaningful improvement activities.

Please reference the Ryan White Part A Program Cleveland TGA 2020 Clinical Quality Management Plan on Page 173 for more information such as CQM infrastructure, capacity building, performance measurement, QI projects and monitoring, stakeholder involvement, evaluation, and communication within the committee.

Annual Monitoring Site Visit Process - Ryan White Part A

Purpose of the Site Visit

The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the Ryan White Recipient conduct an annual site visits with each Sub-Recipient to ensure compliance on proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place.

Sub-Recipient Responsibility

- Providers are required to maintain an individual case record or medical record for each client served.
- All billed services match services documented in client records.
- All records are kept in a secure place and in an organized fashion and available at the start of the monitoring visit.
- Providers review and are familiar with service monitoring tools.
- Assembling and preparing all necessary records and materials for completion of the service monitoring tools by the Recipient.
- Have knowledgeable staff available to answer questions that may arise.
- Make available to the Recipient all materials listed in Attachment A and Attachment B.
- Submit to the Recipient Fiscal Policies within one week of receipt of electronic notification of site visit.
- Provide timely follow-up when identified from the Recipient.

Ryan White Recipient Responsibility Prior to the Visit

- Providers will be notified electronically no later than ten days prior to an on-site visit of the date(s) and time(s) of visit.
- The electronic notification will include **Attachment A – Fiscal Monitoring Site Visit Checklist, Attachment B – Program Monitoring and Site Visit Checklist.**
- The Recipient will review the previous year's fiscal, program and quality monitoring report and corrective action if applicable.
- No later than two (2) days before the monitoring site visit, the Recipient shall provide **Attachment C, Monitoring Site Visit Random Sample Form,** or the final list of records to be reviewed.

Ryan White Recipient Responsibility during the Site Visit

Conduct Opening Conference

- Upon arrival at the monitoring location, Recipient staff will meet with appropriate provider staff to discuss the purpose of the visit, review prior year monitoring outcomes, and address any questions the provider staff may have. The provider staff will be asked to explain how their charts or electronic medical records are organized so that data is accurately collected.

Perform Monitoring

- Recipient staff will review the requested charts and documents as outlined in the notification, using the monitoring tools. A random sample of client records is chosen for review as a means of verifying that services are being provided in accordance with established standards and recorded accurately. In order to ensure efficiency and accuracy of the monitoring process, appropriate provider staff must be available to Recipient staff when needed throughout the monitoring process.

Ryan White Recipient Responsibility Following the Site Visit

Recipient will send a formal written report of the site visit findings

- A formal written report summarizing the monitoring site visit, including findings and recommendations, will be sent to each provider within 30 days of the site visit.

Provide Technical Assistance

- Recipient staff will offer to provide technical assistance training on areas where deficiencies were noted.

Conduct additional site visits as necessary

- Recipient office reserves the right to conduct additional site visits as necessary to verify the implementation of any recommended quality improvement activities.
- Recipient staff will conduct a Follow-Up Site Visit when a provider receives a score of less than 69% on qualifying standards of the site visit report.
- Recipient staff will conduct a focused audit during any Follow-Up Site Visit within (6) six months following the adoption of a recommended Quality Improvement Plan.

Monitoring Performance Scale

QUALITY SCORE	QUALITY RATING	FOLLOW-UP ACTION
90 – 100%	**Excellent** Findings exceed quality expectations	No Action Required.
80 - 89%	**Effective** Findings meet quality expectations	No Action Required.
70 - 79%	**Moderate Deficiencies** Findings are below quality expectations	Written Corrective Action Plan required within 30 days of receipt of report.
69% and below	**Significant Deficiencies**	Probationary Period put in effect; Written Quality Improvement Plan required within 30 days; Services will be re-monitored until provider has addressed the finding and becomes compliant.

Significant Deficiencies Found during Visit

Quality Improvement and Corrective Action Plans

- When a programmatic site visit leads to the discovery of serious concerns about the quality of services that might negatively impact the health and safety of clients, Recipient staff will meet with the provider. The Recipient staff will provide a detailed overview of the concerns. This meeting will determine the appropriate manner in which the findings should be addressed and the appropriate sanction, if any, which should be imposed until the findings have been corrected.
- A Monitoring Performance Scale is used to determine when Quality Improvement Plans and Corrective Action Plans are necessary. Both plans address areas of deficiency, discuss changes that will be made to address deficiencies, and include a timeframe for implementation. Recipient staff will evaluate the provider's written response and notify the provider in writing of any findings to which the provider's response is not adequate. Depending on the severity of the deficiency, more than one monitoring visit during the grant cycle may be required.

- Any provider scoring between 70% and 79% on a qualifying standard will be required to submit a written Corrective Action Plan (CAP) to address the deficient areas within 30 days from the date of receipt of the monitoring report. The CAP must be implemented by the provider within 30 days of submission. The CAP will then be monitored during targeted trainings and technical assistance, as well as routine site visits. Any agency that does not achieve a satisfactory score of 80% on any standard will be subject to a re-monitoring site visit after 6 months. (see Page 4 for Sample Corrective Action Plan)
- Any provider receiving a quality score of 69% or below on a qualifying standard will require immediate follow-up. A written Quality Improvement Plan (QIP) will be required within 30 days of receipt of the monitoring report. The provider will have 30 days to implement the QIP from date of submission. The services will be re-monitored. Further action may be required if sub-recipient continues to have challenges.
- The "Plan-Do-Study-Act" (PDSA) quality improvement model will be used to initiate all quality improvement activities.

Random Sampling

The sample population is randomly selected from a pool of unduplicated Ryan White Part A clients who received services during the designated audit period. Please note that the random selection of unduplicated clients may change at the discretion of the Recipient staff. An **estimate** of sample sizes is listed below:

- 50-100% of files/charts for agencies with **20 Ryan White Part A clients or fewer**
- 25-50% of files/charts for agencies with **21 to 100 Ryan White Part A clients**
- 10-25% of files/charts for agencies with **101 to 500 Ryan White Part A clients**
- 3-10% of files/charts for agencies with **501 clients Ryan White Part A or more**

Please note, prior monitoring report outcomes may be considered and used to reduce the outlined sample size configurations listed above.

Newly Funded Sub-Recipients

- For newly funded Sub-Recipients in a grant year, the Recipient will conduct an orientation site visit within four months of commencement of services. This site visit is an opportunity for the Recipient staff to give an overview of the roles and responsibilities of the Recipient and Sub-Recipient.
- The orientation site visit will consist of a review of the monitoring tools, a review of the program, fiscal, and service delivery requirements.

Previously Funded Sub-Recipients

- Because services are monitored in the year following the service delivery, an agency may no longer be under contract but may be required to participate in an on-site monitoring visit. The process outlined above will still be in effect for those agencies, however, corrective action plans will only need to be submitted for agencies wishing to apply for funding in the future.

Sample Corrective Action Plan:

A Corrective Action Plan sample is listed below, the full version of the document in Word format is available on the CCBH website at: ***www.ccbh.net/ryan-white-provider-resources***

This form should be seen as only a sample; Sub-Recipients may choose to alter the form in any way to meet their own agency needs.

Finding: (Please include detailed description of audit finding)		
Corrective Action Plan: (Please detail the corrective action that will take place to fix the finding, including objectives, goals, and activities)		
Anticipated Completion Date:		
Person/Department Responsible:		
Position:	**Phone:**	**Email:**

Appendices

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Cleveland TGA Ryan White Part A
Eligibility Application

1) Reason for application ☐ New Client ☐ Semi-Annual Recertification with Changes ☐ Annual Recertification

2) Name First _____ **Middle** _____ **Last** _____

3) Date of Birth __ __ / __ __ / __ __ __ __ **4) CAREWare ID** ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

5) Ethnicity
☐ Hispanic/ Latino/a or Spanish origin
☐ Non-Hispanic/Latino/a or Spanish origin

6) Hispanic Subgroup
If the response to Ethnicity is "Hispanic/Latino/a Origin", select all that apply

☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Hispanic, Latino/a or Spanish origin

7) Race
Select all that apply
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander
☐ White

8) Asian Subgroup
If the response to Race is "Asian, select all that apply
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian

9) Native Hawaiian/Pacific Islander Subgroup
If the response to Race is "Native Hawaiian or Other Pacific Islander," select all that apply
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

10) Gender
☐ Male
☐ Female
☐ Transgender
☐ Unknown

11) Transgender Status
If the response to Gender is "transgender" select transgender status
☐ Male to Female
☐ Female to Male

12) Sex at Birth
☐ Male
☐ Female

13) Housing Status
☐ Stable Permanent Housing

☐ Temporary Housing
☐ Unstable Housing

14) HIV/AIDS Status
☐ HIV-positive, not AIDS
☐ HIV-positive, AIDS status unknown
☐ CDC-defined AIDS
☐ HIV-negative (affected)
☐ HIV-indeterminate (infants <2 years only)

15) Year of HIV Diagnosis ___ ___ ___ ___

16) Risk Factor for HIV infection
Select all that apply
☐ Men who have sex with men (MSM)
☐ Injection drug user (IDU)
☐ Hemophilia/coagulation disorder
☐ Heterosexual contact
☐ Receipt of transfusion of blood, blood components, or tissue
☐ Mother with/at risk for HIV infection (perinatal transmission)
☐ Risk factor not reported or not identified

A. Residency

Address _____ **City:** _____ **State:** ____ **Zip:** __ __ __ __ __

County_____

Residency Documentation (select one):

☐ Paystub (Issued within the last 60 days) ☐ Unexpired Ohio Driver's License of State ID
☐ Current Lease/Letter from Landlord ☐ Medicaid enrollment documentation with client county and/or address
☐ Current award letter- government benefits/program ☐ Current utility, phone, other bills in client's name
☐ Envelope addressed to client with cancelled postage (within the last 30 days).
☐ Notarized letter from resident providing housing for client stating that client resides at that address.
☐ Other

B. Modified Adjusted Gross Income (MAGI)

Income sources in this table are required, but are *not* included in MAGI	
Supplemental Income from Social Security (SSI)	$
Child Support Received, Workers Comp., Monetary Gifts	$

Income Included in MAGI

Income Sources	**Monthly Household Amount**
Wages, Salaries, Tips, etc.	$
Disability Income from Social Security (SSDI)	$
Retirement income form Social Security (SSA)	$
Other: Specify from List-	$
Other: Specify from List-	$
Total Income[A]=	**$**

Adjustments Subtracted from Income

Adjustment Type	**Monthly Household Amount**
Alimony Paid	
Tuition and Fees	
Other: Specify from List-	
Total Adjustments[B]=	**$**

Modified Adjusted Gross Income (MAGI)

MAGI Calculation (below): Total Income – Total Adjustments = **Monthly MAGI**

Total Income[A]	**Subtract**	**Total Adjustments[B]**	**Monthly MAGI***
$	Minus	$	**$**

Federal Poverty Level (FPL)		
*Monthly MAGI	Family Size	Federal Poverty Level (FPL)
$		%

Income Documentation, Examples Include (select all that apply):

- ☐ Current award letter- government benefits/program
- ☐ Documentation of Medicaid enrollment
- ☐ Paystubs (Two in last 60 days)
- ☐ Self-Employment business records
- ☐ Prison release papers (within last 60 days)
- ☐ Copy of last year's tax return
- ☐ Workers compensation documents
- ☐ Other

Self-Attestation of No Income

I, _____ (name of client) certify that my income was zero for the past ____ months.

How I have supported myself/family while having no income be specific (Required):

_____

_____

_____

C. HIV Status (Initial Eligibility Only)

☐ Confirmed HIV diagnosis (reference CDC guidelines)

☐ Lab results at any time during the client's lifetime that show the presence of the HIV (detectable viral load) that includes the name of the client and testing facility

☐ A letter signed by an M.D. on the physician's letterhead that includes either: 1) A statement that the client is receiving services for HIV/AIDS, or 2) A statement of quantitative viral load.

☐ Preliminary Positive

D. Insurance Status

Insurance Status Documentation- Select all that apply

☐ Private- Employer ☐ Private- Individual ☐ Medicare ☐ Medicaid, CHIP, or other public plan

☐ Veterans Health Administration (VA), military health care (TRICARE), and other military health care

☐ Indian Health Service ☐ No Insurance/Uninsured ☐ Other

E. Certification

Client Attestation:

The information provided in this application is true and accurate to the best of my knowledge. Any unreported income or insurance coverage may result in the loss of eligibility.

Today's Date __ __ / __ __ / ___ ___ ___ ___

Client Printed Name_____ Client Signature_____

Ryan White Agency:

Staff Name (Printed)_____ Date: _____

Staff Signature_____ Phone Number (__ __ __) __ __ __ - __ __ __ __

Date Eligibility Established __ __ / __ __ / __ __ __ __ **Date Eligibility Expires** __ __ / __ __ / __ __ __ __

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Ryan White Part A- Cleveland TGA
Semi-Annual Recertification- No Changes

Date Eligibility Recertified: __ __/ __ __ / __ __ __ __ Annual Recertification due by: __ __/ __ __ / __ __ __ __

Date: __ __/ __ __ / __ __ __ __

Client Name: _____ Date of Birth: __ __/ __ __ / __ __ __ __

CAREWare ID: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Client Certification of No Changes

Please initial each statement and sign below:

_____ There have been no changes to my address, household income, insurance coverage, or other information that may affect my eligibility for the Ryan White program since my eligibility was last established/recertified.

_____ My eligibility for the Ryan White Program must be established at least every six months, or it will expire.

_____ If there are any changes to my eligibility information before my Annual Recertification is due, I will report them and provide documentation of the changes.

Today's Date ___ ___ / ___ ___ / ____ ____ ____ ____

Client Signature_____

Client Printed Name_____

AGENCY USE ONLY

Staff Signature: _____ Date: _____

Printed Name:_____

Phone Number: (__ __ __) __ __ __ - __ __ __ __ Agency: _____

Ryan White Part A

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Early Intervention Services (EIS):

Counseling individuals with respect to HIV/AIDS; testing (not funded through Ryan White Part A); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

RWHAP Part A EIS services must include the following four components:

1) Targeted HIV testing (not funded through Ryan White Part A) to help the unaware learn their HIV status and receive referrals to HIV care and treatment services if found to be HIV infected. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
2) Referral services to improve HIV care and treatment services at key points of entry
3) Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
4) Outreach services and Health Education / Risk Reduction related to HIV diagnosis

Services should be targeted to the following populations:

- Newly diagnosed
- Receiving other HIV/AIDS services but not in primary care
- Formerly in care – dropped out
- Never in care
- Unaware of HIV status

EIS programs must have signed linkage agreements to work with key points of entry.
Given that EIS leads EIIHA (Early Identification of Individuals with HIV/AIDS) efforts, EIS programs must coordinate with prevention services, counseling and testing centers, as well as other RW Part A providers.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Ryan White Part A

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

An individual providing Early Intervention Services (EIS) must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

All EIS staff working outside of a primary medical care facility must be certified by the Ohio Department of Health as an HIV Prevention Counselor and Tester as evident through certification on file, or, if partnering with an outside testing agency, have the partnering agency's staff certification on file.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of EIS is to bring identified high risk clients into, or back into, medical care through intensive short-term case management services.

Clinical Quality Improvement outcome goals for EIS are:

- 100% of all EIS client files include documentation of referral to health care and supportive services.
- 80% of EIS clients are linked to care as documented by at least one medical visit, viral load or CD4 test within 90 days of first visit/service.

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Early Intervention Services are provided by qualified professionals.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable targeted subpopulations as documented through staff personnel records.	100%
2.	Agencies providing EIS include testing, referral, linkage and education program components into their project work plans.	Documentation of the provision of all four required service components with Part A funding or other funding partnerships available for review.	100%
3.	Agencies providing EIS have established memoranda of understanding (MOUs) with key points of entry into care and linkage agreements with partnering testing agencies.	Documentation of all executed MOUs and linkage agreements available for review.	100%
4.	Agencies providing EIS coordinate project activities with HIV prevention efforts and programs.	Documentation that agency's work in partnership with prevention services as to not duplicate any service activities.	100%
5.	All EIS HIV testing activities meet CDC and State testing requirements.	If providing EIS services outside of a primary medical care facility, documentation of ODH HIV Prevention Counselor and Tester certification or equivalent for staff from formal partnering agency is made available for review.	100%
6.	Agencies providing EIS document and report all administered HIV tests and positive screenings.	Documentation of monthly tracking of administered HIV tests and positives made available for review.	100%
7.	Agencies providing EIS track all referrals to and from the program.	Documentation of the number of referrals from key points of entry to the EIS program and to health care and supportive services from EIS made available for review.	100%
8.	EIS client can be associated with one or more of the five target populations.	Documentation of need for EIS services is evident in the client file.	80%
9.	EIS clients receive health education and literacy training that enables them to better navigate the HIV system of care.	Documentation of health education and literacy training is included in the file of all clients receiving services in the measurement year.	80%
10.	EIS clients are referred to health care and supportive services.	Documentation of referrals to health care and supportive services are included in the file of all clients receiving services in the measurement year.	80%
11.	* Clients are transitioned out of EIS once EIS objectives are met and/or client is proven to be in stable medical care.	* Documentation is included as an EIS notation that the client has been referred and/or transferred out of EIS services once noted as stably in medical care.	80%
12.	EIS clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within 90 days of first EIS visit/service.	80%
13.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year (Not applicable if client is newly diagnosed within 6 months of the grant year end).	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

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Revised March 2019

CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A
Cleveland TGA

Ryan White Part A

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Emergency Financial Assistance:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential medications or prescription eye wear. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted. Agencies providing medication assistance under Emergency Financial Assistance must be a current Cleveland Ryan White Part A provider of Outpatient Ambulatory Health Services with the required 340B certification.

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White HIV/AIDS Program funds for these purposes will be the payer of last resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should not be funded through EFA.

* Requests for exceptions must be submitted to the Grantee through the Cuyahoga County Board of Health Ryan White Part A Program Service Exception Request Form.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Emergency Financial Assistance (EFA) service providers dispensing medications shall adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Ohio.

EFA providers providing medication assistance must also be enrolled in the Federal 340B Drug Pricing Program.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of the Emergency Financial Assistance (EFA) program is to provide formulary approved HIV/AIDS medications or prescription eye wear on a temporary basis to eligible individuals living with HIV/AIDS in the TGA to ensure access to therapies for improved and/or sustained health.

Clinical Quality Improvement outcome goals for EFA include:

- 80% of all files include an assessment of presenting need and qualification for EFA service.
- 80% of EFA clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year

Ryan White Part A

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Service providers dispensing medications adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Ohio.	Documentation of current pharmacy license for the State of Ohio is reviewed.	100%
2	Service provider is enrolled in the Federal 340B Drug Pricing Program.	Documentation of current 340B certification is reviewed.	100%
3	Client file includes an assessment of presenting problem / need requiring EFA services.	Documentation of eligibility and need evident in the client chart.	80%
4	Client file includes a description of the date and type of EFA provided.	Documentation of date and description of EFA drug(s) distributed evident in the client chart.	80%
5	Drugs distributed under EFA are included on the approved Ohio Drug Assistance Program formulary or the agency has received prior approval through the exception request process with the Grantee.	Documentation that distributed drug(s) is/are on the approved formulary or have received prior-approval evident in the client chart.	80%
6	* Client file includes documentation that a third party application was completed and is pending approval.	* Documentation of a third party payer application evident in the client chart.	80%
7	Client did not receive EFA services for longer than 90 days.	Documentation that EFA services were limited to 90 days or less evident in the client chart.	80%
8	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report)	80%
9	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Food Bank/Home Delivered Meals

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Food Bank/ Home Delivered Meals:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Unallowable costs include household appliances, pet foods, and other non-essential products.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Food Bank/Home Delivered Meals

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Any agency providing services in the Food Bank/Home Delivered Meals (FB/HDM) category must comply with federal, state, and local regulations regarding the provision of food bank services, food item delivery and/or home delivered meals including any required licensure and/or certifications to operate the particular food service program involved.

All personnel being billed for delivering meals and/or any food items must hold a valid Ohio driver's license and automobile insurance consistent with state minimum requirements. This also applies to delivery personnel whose agencies may have customized their FB/HDM programs as detailed in their proposal to the Grantee.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Food Bank/Home Delivered Meal services is to assist eligible people living with HIV/AIDS in the TGA with food assistance to ensure access to adequate caloric intake and balances nutritional meals to optimize health outcomes.

Clinical Quality Improvement outcome goals for Food Bank/Home Delivered Meals are:

- 100% of all agencies providing services maintain proper licensure as required by the state of Ohio, pertaining to program service delivery approved by the Grantee.
- 80% of food bank/home delivered meal clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Ryan White Part A

Food Bank/Home Delivered Meals

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Food Bank/Home Delivered Meal services are provided by agencies that maintain appropriate required licensure.	Documentation of appropriate food licensure or licensure required for food delivery personnel reviewed. ***For clarification, please see Personnel Qualifications section above**	100%
2	Agencies providing Food Bank/Home Delivered Meals collect and maintain signed receipts for all resources distributed.	Documentation of a signed receipt for all services received is maintained and available for review in the client chart.	100%
3	* Clients receiving home delivered meals have documented medical necessity of need updated at least every six months (~180 days) or sooner if noted by physician.	* A written physicians referral documenting the home delivery as a medical necessity including the diagnosis and length of time the physician expects the patient will require home delivered meals is evident in the client chart.	80%
4	Food Bank/Home Delivered Meal clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart.	80%
5	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Ryan White Part A

Food Bank/Home Delivered Meals

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Home and Community-Based Health Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Home and Community-Based Health Services:

Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Home and Community-Based Health Services

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Staff providing Home and Community-Based Health Services may include, but are not limited to: home health aids, nurses, physical therapists, and/or social workers. Depending on the scope of practice, staff must meet the appropriate licensure and/or certification requirements set forth by the State of Ohio where applicable.

Each agency providing Home and Community-Based Health Services must have and implement a plan for supervision of all staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Home and Community-Based Health services within the Cleveland TGA is to provide high quality in-home services that assist with increasing activities of daily living (ADL) and adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for Home and Community-Based Health Services include:

- 80% of Home and Community-Based Health Services clients have a written care plan signed by a clinical health care professional.
- 80% of Home and Community-Based Health Services clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Ryan White Part A

Home and Community-Based Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Home Health Care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Home Health Care agencies are appropriately licensed by the state of Ohio and able to bill Medicare, Medicaid, private insurance, and/or other third party payers.	Documentation of agency licensure/s reviewed.	100%
3	Client file includes written care plan signed by a clinical health care professional indicating the need for services.	Documentation of care plan evident in client chart.	80%
4	Client file includes written care plan that specifies type of services needed and the quantity and duration of care	Documentation of care plan evident in client chart.	80%
5	* Client written care plan is reviewed and/or updated at least every 90 days.	* Documentation of treatment plan update evident in client chart.	80%
6	Client file includes documentation of type of home service provided, the date of service, and the signature of the professional who provided each service.	Documentation of service details and professional signature evident in client chart.	80%
7	* Client file includes documentation of ongoing communication with the client's health care team (i.e. referring physician; medical case manager).	* Documentation of communication with client's health care team evident in client chart.	80%
8	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report)	80%
9	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CARE-Ware Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Ryan White Part A

Home and Community-Based Health Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Home Health Care

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Home Health Care:

Is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostic testing administered in the home
- Other medical therapies

Services require a medical referral stating the need for home health services and the expected length of care. The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Home Health Care

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Home Health Care services will be provided by trained licensed or certified health care workers such as nurses. Depending on the scope of practice, staff must meet the appropriate licensure and/or certification requirements set forth by the State of Ohio.

Each agency providing Home Health Care must have and implement a plan for supervision of all staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Home Health Care services within the Cleveland TGA is to provide high quality in-home services that assist with increasing activities of daily living (ADL) and adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for Home Health Care services include:

- 80% of Home Health Care clients have a written care plan in place.
- 80% of Home Health Care clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Ryan White Part A

Home Health Care

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Home Health Care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Home Health Care agencies are appropriately licensed by the state of Ohio and able to bill Medicare, Medicaid, private insurance, and/or other third party payers.	Documentation of agency licensure/s reviewed.	100%
3	Client file includes documentation of type of home service provided, the date of service, and the signature of the professional who provided each service.	Documentation of services provided and provider signatures evident in client chart.	80%
4	Client file includes documentation that services are limited to medical therapies in the home and exclude personal care services.	Documentation of services provided evident in client chart.	80%
5	* Client file includes documentation of the physician referral for home health care services and expected length of time that services will be needed.	* Documentation of physicians referral evident in client chart.	80%
6	* Client file includes documentation that the treatment plan is reviewed and/or updated at least every 90 days.	* Documentation of treatment plan update evident in client chart.	80%
7	* If client is discharged, client file includes reason for termination of services.	* Documentation of reason for discharge evident in client chart.	80%
8	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report)	80%
9	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Home Health Care

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Medical Case Management

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Case Management:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial and updated psychosocial assessment of service needs, along with acuity scale
- Development of a comprehensive, individualized care plan, with updates
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefit counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplace/Exchanges).

Individuals providing medical case management must be a licensed social worker and are expected to have specialized training in medical case management models.

Medical Case Management includes all provisions listed above and requires a patient whose acuity level requires the case manager also manage their medical care, schedule and monitor medical appointments, lab work, medication treatment adherence, other indicated services including dietician, mental health and substance abuse screenings/treatment and other supports.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Medical Case Management

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

An individual providing medical case management services must be a licensed social worker and follow the National Association of Social Work (NASW) Standards for Case Management, available for review at: www.socialworkers.org/practice/naswstandards

Each medical case management agency must have and implement a written plan for supervision of all medical case management staff consistent with licensure status. Medical case managers must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical case management is to provide care planning and coordination services needed for people living with HIV/AIDS, ensuring access to core and support services that will enable medical adherence and stability for each individual client.

As part of this service category, all medical case managers are required to administer a standardized psychosocial assessment and complete an accompanying acuity scale every six months, for every client on their caseload.

Clinical Quality Improvement outcome goals for medical case management are:

- 100% of all client files include documentation of a completed comprehensive care plan.
- 80% of clients receiving medical case management services are actively engaged in medical care as documented by a medical visit in each six (6) month period in a two year measure and in the second half of a single year measure.
- 80% of clients receiving medical case management services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 80% of clients receiving medical case management services are virally suppressed as documented by a viral load of less than 200 copies/mL at last test.
- 100% of clients receiving medical case management services receive a psychosocial assessment and have an acuity scale completed every 6 months in the measurement year.

Ryan White Part A

Medical Case Management

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Medical case management clients have a completed comprehensive individual care plan.	Documentation of completed comprehensive individual care plan is included in the file of all clients receiving services in the measurement year.	100%
3	New medical case management clients receive an initial psychosocial assessment of service needs.	Documentation of initial assessment of service needs is included in the file of all clients entering service in the measurement year.	100%
4	Medical case management clients receive coordinated referrals and information for services required to implement the care plan.	Documentation of referrals and service coordination are noted in the file for clients receiving services in the measurement year.	100%
5	Medical case management clients have their individual care plans updated two or more times, at least three months apart.	Documentation that the individual care plan is updated at least two times, three months apart, for clients receiving services for a span longer than six months in the measurement year.	80%
6	Medical case management clients are continuously monitored to assess the efficacy of their individual care plan.	Documentation of continuous monitoring to assess the efficacy of the care plan is evident in the client chart.	80%
7	Medical case management clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented by the medical case manager.	80%
8	Medical case management clients are retained in medical care	Documentation that the client had at least one medical visit in each six month period of a 24 month measurement period with a minimum of 60 days between visits as documented by the medical case manager.	80%
9	Medical case management clients have no gaps in medical care.	Documentation that the client had a medical visit in the first and second halves of a 12 month measurement period as documented by the medical case manager.	80%
10	Medical case management clients are on Antiretroviral Therapy (ART).	Documentation that client was prescribed ART in the 12 month measurement year as documented by the medical case manager.	80%
11	Medical case management clients are virally suppressed.	Documentation that the client has a viral load <200 copies/mL at last test as documented by the medical case manager.	80%

*All standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Revised January 2019

CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A Cleveland TGA

Medical Case Management

Cleveland TGA Service Standard of Care

SERVICE STANDARDS (CONT'D)

	Standard	Measure	Goal
12	Medical case management clients have a completed acuity scale based on most recent psychosocial assessment.	Documentation of completed acuity scale is included in the file of all clients receiving services in the measurement year.	100%
13	Medical case management clients receive an updated psychosocial assessment of service needs every six months.	Documentation of updated psychosocial assessment of service needs is included in the file of all clients entering service in the measurement year.	100%
14	Medical Case Management clients have been educated on viral suppression and transmission (i.e. U=U)	Documentation that client had discussion with healthcare professional about viral suppression and transmission (i.e. U=U)	80%

*All standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Medical Case Management

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Nutrition Therapy:

Medical Nutrition Therapy includes:

- Nutritional assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutritional education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/ Ambulatory Health Services. All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Depending on the scope of practice, an individual providing medical nutrition therapy must be licensed and qualified within the laws of the State of Ohio by one of the following licensing boards:

- Ohio Board of Dietetics
- American Dietetic Association

Each agency providing medical nutrition therapy must have and implement a plan for supervision of all medical nutrition staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical nutrition therapy within the Cleveland TGA is to provide high quality treatment and counseling services to address the nutritional needs of individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for medical nutrition therapy include:

- 80% of all medical nutrition therapy clients have a nutrition plan in place.
- 80% of medical nutrition therapy clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Ryan White Part A

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Medical nutrition therapy services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	* Staff providing services have been trained to work within the population.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	80%
3	Client file includes date service was initiated and the planned number and frequency of sessions.	Documentation of initiation date and frequency plan evident in client chart.	80%
4	Client file includes a nutrition plan with recommended services and course of medical nutrition therapy provided with signature of assigned medical nutrition therapist.	Documentation of nutrition plan and professional signatures evident in client chart.	80%
5	* Nutrition Plan is updated as necessary and signed by RD annually.	Documentation of nutrition plan updates evident in client chart.	80%
6	Where food prescription is indicated, client file includes physician's recommendation for services.	Documentation of physician's recommendation evident in file.	80%
7	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client reported).	80%
8	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Ryan White Part A

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Medical Transportation

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Transportation Services:

Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Medical transportation may be provided through:

- Contracts with providers for transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Organization and use of volunteer drivers (though programs with insurance and other liability issues specifically addressed)
- A voucher or token system

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Revised March 2019

CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A
Cleveland TGA

Medical Transportation

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Staff administering medical transportation services must possess a comprehensive knowledge of local transportation assistance options and internal medical transportation policies. This policy must be on file at the Cuyahoga County Board of Health.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical transportation is to provide transportation services needed for people living with HIV/AIDS to ensure access to core and support services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for medical transportation are:

- 80% of medical transportation files include the reason for each trip and its relation to accessing health and support services.
- 80% of medical transportation clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Ryan White Part A

Medical Transportation

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Medical transportation client file includes a description of the level of services/number of trips provided.	Documentation of service evident in client chart.	80%
2	Medical transportation client file includes the reason for each trip and its relation to accessing health and support services	Documentation of allowable activities evident in client chart.	80%
3	If providing gas cards or taxi assistance, the medical transportation client file includes the trip origin and destination	Documentation of trip origin and destination evident in client chart.	80%
4	If providing gas cards, the mileage reimbursement does not exceed the federal reimbursement rate.	Documentation of federal reimbursement rate calculations evident in client chart.	80%
5	Medical Transportation client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client self report)	80%
6	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

All standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Medical Transportation

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Appendix A: Service Delivery and Documentation Requirements

UNIVERSAL SERVICE DELIVERY REQUIREMENTS

Vouchers
Where direct provision of medical transportation is not possible or effective, vouchers, coupons, or tickets that can be exchanged for medical transportation services must be used.

Agencies must administer voucher programs in a manner which assures that vouchers cannot be used for anything other than the allowable medical transportation service, and that systems are in place to account for disbursed vouchers.

A medical transportation voucher is a public transportation ticket or pass, fuel-only reimbursement card, disability ID form, parking pass, or taxi pass.

Allowable Appointments
Medical transportation may only be provided to an eligible client to access HIV-related health services, which may include services needed to the maintain the client in HIV/AIDS medical care.

Cost-Effectiveness
Medical transportation must be provided in the most cost-effective manner that addresses the client's medical condition and timeliness concerns.

Agency Policies and Protocols
Agencies must have written Medical Transportation Services policies and protocols which are compliant with Ryan White program requirements.

SERVICE DELIVERY METHOD REQUIREMENTS

Public Transportation:
Agencies may distribute public transportation vouchers to clients to access allowable appointments. Agencies will be approved to either purchase public transportation vouchers directly and be reimbursed for those purchases or the Recipient/Grantee may choose to purchase and transfer vouchers to the agencies.

Public Transportation Disability ID:
The Recipient/Grantee may choose to distribute vouchers to agencies that clients may exchange for a public transportation disability ID at no cost to the client. The Recipient/Grantee will be directly billed for the costs of the vouchers.

Cleveland TGA Service Standard of Care

SERVICE DELIVERY METHOD REQUIREMENTS CONTINUED

Mileage Reimbursement:
Agencies may reimburse clients with fuel-only vouchers for documented mileage driven in order to access allowable appointments. Agencies will be approved to either purchase fuel-only vouchers directly and be reimbursed for those purchases or, the Recipient/Grantee may choose to purchase and transfer fuel-only vouchers and distribute them to the agency.

Parking Vouchers:
Agencies may issue parking vouchers to clients to access an on-site allowable appointment.

Transportation Services:
When no other means of transportation is available or appropriate, agencies may provide taxi or other vouchers to clients in order to access allowable services.

*All state licensure and insurance requirements must be followed.

DOCUMENTATION REQUIREMENTS

Agencies must maintain organized files that document:

- The transportation method used to meet the transportation need;
- The level of services/number of trips provided;
- Trip origin and destination;
- Trip documentation from named destination points for mileage reimbursement;
- The reason for each trip and its relationship to accessing HIV-related health services, which may include services needed to maintain the client in HIV/AIDS medical care; and
- The cost per trip.

A sample medical transportation documentation form is included as *Appendix B*.

Appendix B: Medical Transportation Form Sample

CUYAHOGA COUNTY BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Cleveland Transitional Grant Area- Ryan White Part A

Medical Transportation Form

1. Service Date: _____

2. Client Name: _____ 3. CAREWare ID: _____

4. Was the client screened for other available resources for transportation services? ☐ Yes ☐ No

_____

5. Form Directions- Check the box (A. – D.) for the type of assistance provided and complete related fields.

*Services Accessed- Funds may be used to provide transportation services to an eligible client to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care.

☐ A. Public Transportation

Service(s) Accessed*	Date(s)	Type of Bus Pass	Quantity	Pass/Voucher Number(s)
		RTA Daily Bus Pass ($5.50)		
		RTA Daily Bus Pass- Disabled ($2.75)		
		Other RTA Bus Pass ($_____)		
		RTA ID Voucher- No value until exchanged for RTA ID	N/A	

☐ B. Fuel Card/Mileage Reimbursement OR ☐ C. Cab/Taxi Voucher

Service(s) Accessed*	Miles	Date	Starting Address	Destination Address
Service(s) Accessed*	Miles	Date	Starting Address	Destination Address
Service(s) Accessed*	Miles	Date	Starting Address	Destination Address
Service(s) Accessed*	Miles	Date	Starting Address	Destination Address

Total Miles: _____ Total Fuel Card/Mileage Reimbursement or Taxi/Cab Voucher Amount: $_____

☐ D. Parking Voucher

Service(s) Accessed*	Date(s)	Quantity

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Cleveland TGA Ryan White Part A: MT Form Effective 12/01/2016

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Revised March 2019

CUYAHOGA COUNTY BOARD OF HEALTH Ryan White Part A Cleveland TGA

Ryan White Part A

Mental Health Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Mental Health Services:

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within Ohio to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Mental Health Services

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

Depending on the scope of practice, an individual providing mental health services must be licensed and qualified within the laws of the State of Ohio by one of the following licensing boards:

- Ohio Counselor, Social Worker and Marriage and Family Therapist Board
- Ohio Board of Psychology
- Ohio Board of Nursing
- State Medical Board of Ohio

Each agency providing mental health services must have and implement a plan for supervision of all mental health staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of mental health services within the Cleveland TGA is to provide high quality treatment and counseling services to address mental illness, eliminating barriers to treatment and increasing adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for mental health services include:

- 80% of all mental health clients have a diagnosis of mental illness or a mental health condition.
- 80% of all mental health client files include documentation of a completed comprehensive care plan.
- 80% of mental health services clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Mental Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Mental health services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Clients receiving mental health services have a detailed treatment plan that includes the diagnosis of mental health illness or condition.	Documentation of diagnosis of mental health illness or condition evident in the client chart.	80%
3	Clients receiving mental health services have a detailed treatment plan that includes the treatment modality (group or individual).	Documentation of treatment modality recommendation evident in the client chart.	80%
4	Clients receiving mental health services have a detailed treatment plan that includes the start date for mental health services	Documentation of start date for mental health services evident in the client chart.	80%
5	Clients receiving mental health services have a detailed treatment plan that includes the recommended number of sessions	Documentation of recommended number of sessions evident in the client chart.	80%
6	Clients receiving mental health services have a detailed treatment plan that includes the date for reassessment.	Documentation of recommended date for reassessment evident in the client chart.	80%
7	Clients receiving mental health services have a detailed treatment plan that includes the projected treatment end date.	Documentation of projected treatment end date evident in the client chart.	80%
8	Clients receiving mental health services have a detailed treatment plan that includes any recommendations for follow up.	Documentation of recommendations for follow up evident in the client chart.	80%
9	Clients receiving mental health services have a detailed treatment plan that includes the signature for the mental health professional rendering service.	Documentation of signature for mental health professional rendering the service evident in the client chart.	80%
10	Mental health clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart.	80%
11	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

* All Standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Ryan White Part A

Mental Health Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Non-Medical Case Management Services:

Non-Medical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Services may focus on:

- Housing coordination and referral assistance to enable an individual to gain or maintain access to and compliance with HIV related medical care and treatment. Or,
- Benefit coordination to include assisting eligible clients to obtain access to other public and private programs for which they may be eligible.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individual care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptions as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A Cleveland TGA

Revised March 2019

Ryan White Part A

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga or Medina County)
- ◊ Have an HIV/AIDS Diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of HIV infection, race, creed, age, sex, gender, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

An individual providing non-medical case management services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of non-medical case management services is to provide housing and benefit coordination for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for case management non-medical are:

- 100% of Non-Medical Case Management Services are provided by case managers trained to work with the population that they serve.
- 80% of Non-Medical Case Management clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

CUYAHOGA COUNTY BOARD OF HEALTH Ryan White Part A Cleveland TGA

Revised March 2019

Ryan White Part A

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	* Non-medical case management services are provided by qualified professionals.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2	Client file includes documentation of the date of each encounter.	Documentation of date of encounter evident in client chart.	80%
3	Client file includes documentation of the duration of each encounter.	Documentation of duration of encounter evident in client chart.	80%
4	Client file includes documentation of type of each encounter (e.g. face-to-face, phone, etc.).	Documentation of type of encounter evident in client chart.	80%
5	Client file includes documentation of key activities performed during each encounter.	Documentation of key activities of each encounter evident in client chart.	80%
6	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report)	80%
7	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%
	Non-Medical Case	**Management-Benefit Coordination Only**	
8	Services are focused on assisting client in obtaining access to both public and private benefit programs for which they may be eligible.	Documentation that services tie to benefit coordination evident in client chart.	80%
	Non-Medical Case	**Management - Housing Specialist Only**	
9	* Client file includes a completed individual care plan specific to housing.	* Documentation of completed housing plan evident in client chart.	80%
10	* Client file includes documentation that services are focused on housing information and referrals to enable an individual to gain or maintain access to and compliance with HIV-related medical care and treatment.	* Documentation of activities evident in client chart.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A Cleveland TGA

Revised March 2019

Ryan White Part A

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
11	* Client file includes documentation of completed housing inspection in situations where client relocates.	* Documentation of activities evident in client chart, including housing inspection verified by housing case manager.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

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CUYAHOGA COUNTY BOARD OF HEALTH

Ryan White Part A Cleveland TGA

Revised March 2019

Ryan White Part A

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities on file. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibility.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information for all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the release of information form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another Ryan White Part A provider, the agency must:

- Honor the request for transfer from the client
- Provide the client with a list of other community providers to choose from and
- Transfer a copy of all necessary client records to the new provider upon receipt of written request by the client.

CUYAHOGA COUNTY BOARD OF HEALTH Ryan White Part A Cleveland TGA

Revised March 2019

Ryan White Part A

Oral Health Care

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Oral Health Care:

Oral Health Care services provide outpatient diagnostic, preventative, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Oral Health Care

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

An individual providing Oral Health Services must be a dental health care professional licensed and certified to provide health care in the State of Ohio. Professionals may include:

- General Dental Practitioner
- Dental Specialists
- Dental Hygienists
- Trained Dental Assistants

All services provided must be in compliance with state dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Oral Health Services is to provide diagnostic, preventative and therapeutic dental care to all eligible individuals living within the TGA.

Clinical Quality Improvement outcome goals for oral health services include:

- 100% of all oral health client files have a dental treatment plan developed or updated in the measurement year.
- 80% of all oral health client files include documentation of oral health education provided at least once in the measurement year.
- 80% of oral health clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Oral Health Care

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Oral health clients have a dental treatment plan developed or updated in the measurement year.	Documentation of completed dental treatment plan is included in the file of all clients receiving services in the measurement year.	100%
3	Oral health clients have a dental and medical health history recorded or updated in the measurement year.	Documentation of completed dental and medical health history is included in the file of all clients receiving services in the measurement year.	80%
4	Oral health clients receive oral health education at least once in the measurement year.	Documentation of oral health education is included in the file of all clients receiving services in the measurement year.	80%
5	Oral health clients receive a periodontal screening or exam at least once in the measurement year.	Documentation of periodontal screening is included in the file of all clients receiving services in the measurement year.	80%
6	Oral health clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart.	80%
7	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

* All standards derived from the HRSA/HAB national Monitoring Standards and/or the HRSA/HAB HIV Performance Measures.

Ryan White Part A

Oral Health Care

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Other Professional Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Other Professional Services:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency Planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation of custody options for legal dependents including standby guardianship, joint custody, or adoption

Unallowable services include criminal defense and/or class-action suits unless related to access to services eligible for funding the Ryan White HIV/AIDS Program.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Other Professional Services

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

All legal counsel services must be performed by trained professional staff. Attorneys must have current licensure to practice before a court with jurisdiction in the Cleveland TGA.

Paralegal staff or other non-licensed staff must be supervised by an attorney.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of legal services is to address legal matters directly necessitated by an individuals HIV status so that the client can ensure adherence and maintenance to primary medical care treatment.
Clinical Quality Improvement outcome goals for legal services are:

- 100% of all client files include a completed legal assessment.
- 80% of legal service clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Other Professional Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Legal services are provided by licensed professionals	* Documentation of current licensure to practice before a court with jurisdiction in the Cleveland TGA made available to review.	100%
2.	* Paralegal staff or other non-licensed staff must be supervised by an attorney.	* Documentation that paralegal and other non-licensed staff are supervised by an attorney with supervisory records kept on file and made available for review.	100%
3.	Client file includes a description of how the legal service is necessitated by the individuals HIV status.	Documentation of how the legal service is necessitated by HIV status in included in the file of all clients receiving services in the measurement year.	80%
4.	* Client files include a completed legal assessment.	* Documentation of completed legal assessment is included in the file of all clients receiving services in the measurement year.	100%
5.	Client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client record. (Can be client report)	80%
6.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures.

Other Professional Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Outpatient / Ambulatory Health Services:

Outpatient / Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Non-HIV related visits to urgent care facilities are not allowable costs. Emergency room visits are not allowable costs.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related HIV diagnosis

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
◊ Have an HIV/AIDS diagnosis
◊ Have a household income that is at or below 500% of the federal poverty level
◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Outpatient/Ambulatory Health Services

PERSONNEL QUALIFICATIONS

Outpatient /Ambulatory Health Services must be provided by trained licensed or certified health care workers.

Individual clinicians shall have documented unconditional licensure/certification in his/her particular area of practice as required by Federal, state and local regulations with credentials appropriate for treating HIV-infected clients.

Clinicians are required to:

- Provide direct, ongoing care to at least 20 HIV patients within the 24 months preceding the date of review.
- Complete a minimum of 20 credits of HIV-related CME/CEU/CE or documentation of HIV-related lectures/educational activities within the 24 months preceding the review.

Clinical staff must also have documented unconditional licensure/certification in his/her particular are of practice as required by Federal, state and local regulations and be experienced in the area of HIV/AIDS clinical practice as evident in their personnel files. All clinical staff without direct experience with HIV/AIDS services shall be supervised by one who has such experience. That supervision must be evident in personnel files and made available for review.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Outpatient / Ambulatory Health Services is to provide effective diagnostic and therapeutic medical care services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for Outpatient / Ambulatory Health Services:

- 80% of clients receiving Outpatient Ambulatory Health Services are actively engaged in medical care as documented by a medical visit in each six (6) month period in a two year measure and in the second half of a single year measure.
- 90% of clients receiving Outpatient Ambulatory Health Services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 90% of clients receiving Outpatient Ambulatory Health Services are virally suppressed as documented by a viral load of less than 200 copies / mL at last test.

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	Primary medical care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2	Laboratory services are provided at professional facilities.	Documentation that includes certifications, licenses, or FDA approval of the laboratory from which tests are ordered is reviewed.	100%
3	* Clinicians complete a minimum of 20 HIV-related education credits within the 24 months preceding the date of review.	* Documentation of CME/CEU/CE, lectures, or educational activities received in the 24 months preceding the date of review.	100%
4	* Clinicians provide direct, ongoing care to at least 20 HIV positive clients within the 24 months preceding the date of review.	* Documentation of case load summaries reviewed.	100%
5	Agencies conduct regular quality improvement activities that focus on HIV care and process measures.	Documentation of quality improvement activities reviewed.	100%
6	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident in client chart.	90%
7	Client had viral load test performed at least every six months.	Documentation of viral load test outcomes evident in client chart.	90%
8	Client was prescribed HIV Antiretroviral therapy during the measurement year.	Documentation of HIV Antiretroviral therapy evident in client chart.	90%
9	Client had one medical visit in each 6-month period of a 24-month measurement period with a minimum of 60 days between visits.	Documentation of medical visit history evident in client chart.	80%
10	Client did not have medical visit in the last 6-months of the measurement year.	Documentation of medical visit history evident in client chart.	20%
11	Clients 6 years of age and older are prescribed PCP prophylaxis within 3 months of CD4 count below < 200 cells/mm.	Documentation of PCP prophylaxis prescription evident in client chart.	80%
12	Clients aged 1-5 are prescribed PCP prophylaxis within 3 months of CD4 count < 200 cells/mm.	Documentation of PCP prophylaxis prescription evident in client chart.	80%
13	Clients ages 6 weeks-12 months were prescribed PCP prophylaxis at the time of HIV diagnosis.	Documentation of PCP prophylaxis prescription evident in client chart.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB
National Monitoring Standards and/or the HRSA/HAB
HIV Performance Measures

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Ryan White Part A
Cleveland TGA

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
14	Client had HIV resistance test ordered prior to the initiation of ART if ART is initiated during the measurement year.	Documentation of resistance test evident in client chart.	90%
15	Client had a fasting lipid panel completed if client was on ART during the measurement year.	Documentation of fasting lipid panel evident in client chart.	80%
16	Client had a TB screening test and results interpreted at least once since HIV diagnosis.	Documentation of TB screening test and results evident in client chart.	80%
17	Client received influenza vaccine or reported receipt through other provider between October 1st and March 31st of the measurement year or documentation of client refusal.	Documentation of influenza vaccine evident in client chart.	80%
18	Client ever received pneumococcal vaccine or documentation of client refusal.	Documentation of pneumococcal vaccine evident in client chart.	80%
19	Client had Hep C screening at least once since HIV diagnosis.	Documentation of Hep C screening evident in client chart.	80%
20	Client had Hep B screening at least once since HIV diagnosis.	Documentation of Hep B screening evident in client chart.	80%
21	Client had Hep B vaccine series if not Hep B positive or documentation of client refusal.	Documentation of Hep B vaccine series evident in client chart.	80%
22	Adult female client had pap screen in the last three years, if indicated.	Documentation of pap screening in past three years evident in client chart	70%
23	Client had annual screening for syphilis.	Documentation of annual syphilis screening evident in client chart.	80%
24	Client had annual screening for chlamydia if they were new to services, were sexually active, or had an STI in the last 12 months.	Documentation of annual screening for chlamydia evident in client chart.	80%
25	Client had annual screening for gonorrhea if they were new to services, were sexually active, or had an STI in the last 12 months.	Documentation of annual screening for gonorrhea evident in client chart.	80%
26	Client received an oral exam by a dentist at least once during the measurement year based on client self report.	Documentation or client self-report of reported annual oral exam or referral evident in client chart.	70%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB
National Monitoring Standards and/or the HRSA/HAB
HIV Performance Measures

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
27	Client received HIV risk counseling during the measurement year.	Documentation of HIV risk counseling evident in client chart.	80%
28	Client received screening for clinical depression during the measurement year.	Documentation of clinical depression screening evident in client chart.	80%
28a	If clinical depression screen was positive, client received follow-up plan on the same date of encounter.	Documentation of follow-up plan evident in client chart.	80%
29	Client received screening for tobacco use at least once in a 24 month period.	Documentation of screening for tobacco evident in client chart.	80%
29a	If tobacco screening was positive, client received tobacco cessation counseling intervention or referral.	Documentation of referral or tobacco cessation intervention evident in client chart.	80%
30	New clients received screening for substance use (alcohol & drugs) during the measurement year.	Documentation of substance abuse screening evident in client chart.	80%
31	Outpatient/Ambulatory Health Services clients have been educated on viral load suppression and Undetectable=Untransmittable	Documentation that client had discussion with healthcare professional about viral load suppression and Undetecta-ble=Untransmittable	80%

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs (Retrieved from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each clients file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Psychosocial Support Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Psychosocial Support Services:

Psychosocial Support Services provide group or individual support and counseling services to include HIV support groups to assist eligible people living with HIV to address behavioral and physical health concerns.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- ◊ Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- ◊ Have an HIV/AIDS diagnosis
- ◊ Have a household income that is at or below 500% of the federal poverty level
- ◊ Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Psychosocial Support Services

Cleveland TGA Service Standard of Care

PERSONNEL QUALIFICATIONS

An individual providing psychosocial support services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of psychosocial support services is to provide group support and therapy for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for psychosocial support services are:

- 80% of psychosocial support clients have received education specifically geared towards the importance of medical adherence.
- 80% of psychosocial support clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Psychosocial Support Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1	* Psychosocial Support services are provided by qualified professionals	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2	* Documentation is maintained of all topics discussed through support group with correlating sign-in sheets.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
3	* Access and engagement in primary care topics were discussed with the client at least once in a 3 month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
4	* Access and engagement in medical case management was discussed with the client at least once in a six month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
5	Psychosocial client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report).	80%
6	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Psychosocial Support Services

Cleveland TGA Service Standard of Care

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CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

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CASE CLOSURE PROTOCOL

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Data To Care Initiative

Cuyahoga County Board of Health

Ryan White Part A Program

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

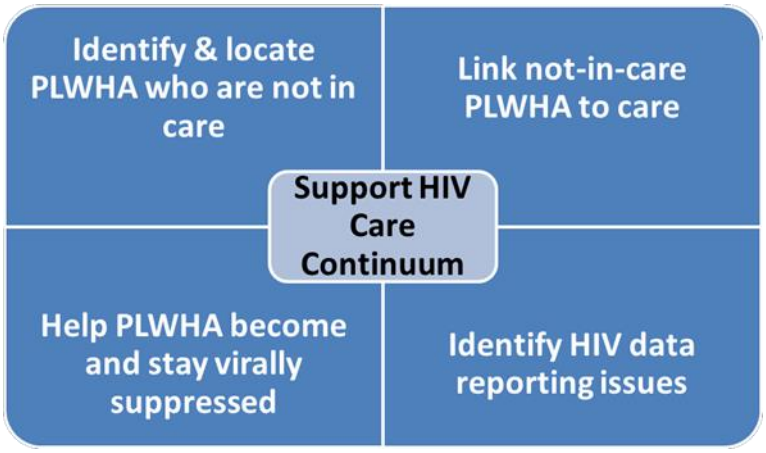
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H89HA23812, Ryan White HIV/AIDS Part A. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Version 1.0 *Version Date: 10/15/2019*

Objective

The purpose of this protocol is to provide an overview of the Data to Care (D2C) program at the Cuyahoga County Board of Health (CCBH). D2C supports the HIV Continuum of Care by utilizing HIV surveillance data to:

(1) identify persons living with HIV/AIDS (PLWHA) in the Cleveland Transitional Grant Area (TGA) who have fallen out of care, have never accessed care after being diagnosed with HIV, or who are in care and not virally suppressed
(2) assist with linkage and engagement in HIV medical care and support services,
(3) help achieve viral suppression, and
(4) identify HIV data reporting issues.



This protocol serves as a Cleveland TGA-specific supplement to the Ohio Department of Health HIV Prevention & Surveillance Data-to-Care Protocol.

Background and Rationale

The Cleveland TGA has a population of 2.1 million people and includes six counties: Cuyahoga, Lorain, Medina, Ashtabula, Lake, and Geauga. There were 5,857 persons living with a diagnosis of HIV/AIDS in the Cleveland TGA at the end of 2018. The prevalence rate of HIV in the Cleveland TGA is 271.8 HIV-diagnosed persons per 100,000 population. HIV prevalence in the Cleveland TGA disproportionately impacts several segments of the population, including Black/African American non-Hispanic persons, youth between the ages of 13 and 29, and men who have sex with men (MSM).

CCBH recognizes that early entry into HIV care and consistent engagement in HIV care has an immediate impact on disrupting the transmission of HIV within the community, as well as a profound effect on the health of persons infected with HIV. As a result, CCBH has prioritized the identification of individuals who have fallen out of care, who have never accessed care after being diagnosed with HIV, or who are in care and not virally suppressed. D2C is one strategy for identifying these individuals.

D2C is an HIV prevention strategy, promoted by the U.S. Centers for Disease Control and Prevention (CDC), that uses HIV surveillance data and HIV-specific laboratory reports as markers for care to identify individuals who may have fallen out of care or who were never linked to care after being diagnosed with

HIV, as well as those who are not virally suppressed. The D2C framework also includes follow-up and early intervention services (EIS) to assist those individuals with getting into HIV care and/or achieving viral suppression. The overall goals of the D2C strategy are to (1) increase the number of HIV-diagnosed individuals who are engaged in HIV care, and (2) to increase the number of HIV-diagnosed persons with an undetectable viral load.

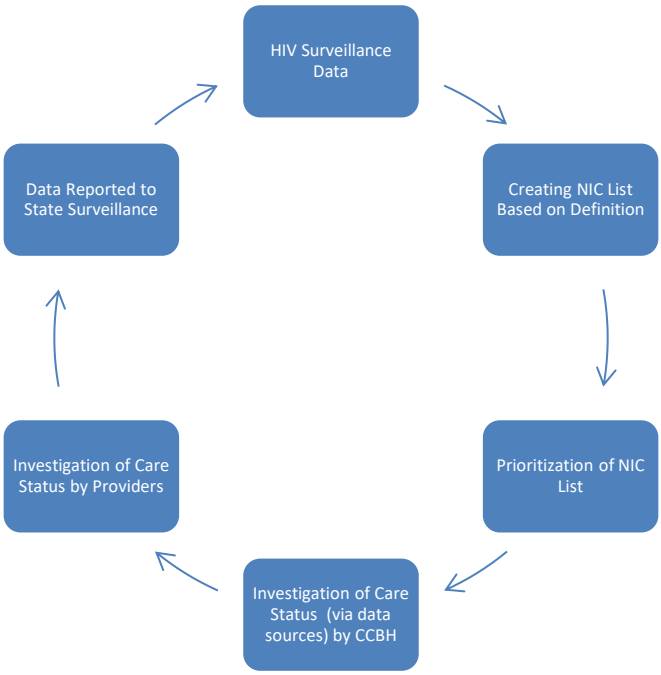
CCBH's D2C program uses a combination Health Department and Health Care Provider Model. This means that CCBH (i.e., the designated health department) is responsible for initiating linkage and engagement for those individuals who have never been linked to a provider since their diagnosis, or those individuals who were last seen by a provider outside the Cleveland Part A network. Part A medical providers (i.e., the health care provider) are responsible for linkage and engagement for those individuals who were last seen at their agency.

The Data to Care Initiative is in line with current Early Intervention Services (EIS) programming that has been in place in the Cleveland TGA for the last ten years. CCBH believes that D2C will provide an additional dataset and approach that will elevate the current EIS approach in programming to improve linkage, retention in care, and viral load suppression within the TGA.

Procedures

HIV surveillance data exported from the Ohio Department of Health (ODH) Enhanced HIV/AIDS Reporting System (eHARS) will be utilized to produce a more detailed HIV epidemiologic profile for the Cleveland Ryan White Part A TGA and provide a more detailed geographic representation of the distribution of HIV within the Cleveland TGA. This information will inform CCBH of strategies and development of programmatic activities. It will also help to inform Planning Council when they conduct Priority Setting and Resource Allocation (PSRA). In addition, outcomes will be shared with the overall HIV community for the purpose of improving all services to HIV clients.

Data to Care Workflow



Generation of NIC List

From eHARS, ODH will identify PLWHA who are potentially not in care and compile a NIC list. To be on the NIC list, a client must:

1. Have had an HIV-positive result reported to the Ohio HIV surveillance database (eHARS)
2. Last known to be living in the Cleveland Part A TGA
3. Meet the ODH definition of NIC: Not have had a routine HIV monitoring lab value (i.e. CD4 or viral load), or other care marker reported to eHARS within a 365 day period

The NIC list file will be provided to CCBH from the Ohio Department of Health in an encrypted, password-protected Excel file. First, CCBH staff will reconcile ODH's list with their own CAREWare Part A client list spanning the same time frame; those with evidence of being in care through Part A will be taken off the NIC list. Next, CCBH staff will use other available databases to further reconcile the remaining names on the NIC list; and further, names with evidence of care will be taken off the NIC list. Thirdly, the remaining names on the NIC list will be sorted by agency; and also those individuals that have never been seen by any provider will be sorted into a separate list. Agencies will be given their specific NIC list via a password-protected file on a flash drive.
The NIC list will include all available demographic and contact information, as well as diagnostic and prognostic laboratory reporting data and provider information, for all persons diagnosed with an HIV infection living within the Cleveland TGA who are believed to not be in care. Data collection fields to

capture this information will be a part of the Excel-file NIC list, and designated staff at each agency will be responsible for entering this data.

CCBH recognizes that the electronic reporting of HIV-specific laboratory tests in the State of Ohio is incomplete. However, CD4 and viral load results are an important primary data source for identifying individuals who have fallen out of care or who were never linked to care after diagnosis. Laboratory data is critical to developing a preliminary list of HIV-positive persons who are not in care.

Additionally, upon review of available data sources, CCBH and Part A providers consider HIV surveillance data exported from eHARS essential to establishing a successful D2C program.

Prioritization of the NIC List for Follow-Up and Referral to EIS

CCBH recognizes that it may not be possible to investigate and follow-up will all individuals identified on the NIC list. Consequently, CCBH may need to identify selection criteria for prioritizing and selecting individuals for follow-up. The Part A office gives priority to those individuals who are not virally suppressed, and also those individuals belonging to a priority population as determined by the most recent Cleveland Part A HIV epidemiology data from the Ohio Department of Health. Also, priority populations will be different in Cuyahoga County than in the outlying counties of the TGA. CCBH will carefully consider any impact such a decision will have on the individuals who may not receive follow-up, as well as the impact on ongoing HIV transmission in the community. The NIC list is prioritized as follows:

Cuyahoga County

1. Individuals who are not virally suppressed based on most recent documented viral load
2. African-American men having sex with men (MSM) under the age of 30
3. African-American MSM
4. African-American males under the age of 30
5. All other persons under the age of 30
6. Clients who have previously received any Ryan White Part A service, as documented in CAREWare, prioritized beginning with most recent service date
7. Anyone with a documented address, phone number, or both
8. All remaining clients

Outlying Counties (Lorain, Medina, Ashtabula, Lake, Geauga)

1. Individuals who are not virally suppressed based on most recent documented viral load
2. White men having sex with men (MSM) under the age of 30
3. White MSM
4. White males under the age of 30
5. All other persons under the age of 30
6. Clients who have previously received any Ryan White Part A service, as documented in CAREWare, prioritized beginning with most recent service date
7. Anyone with a documented address, phone number, or both
8. All remaining clients

Investigation of Care Status for NIC List

Cuyahoga County Board of Health

CCBH staff will investigate the care status of persons identified on ODH's NIC list using a variety of sources, both internal and external to CCBH. Such sources include, but are not limited to:

- CAREWare (Ryan White Part A)
- Ohio Disease Reporting System (ODRS)
- Last known care provider

Those individuals that are determined to be in care based on reconciling with data sources will be taken off the NIC list.

Remaining individuals will be sorted by the last agency to have contact with them, and will be created into a separate agency-specific NIC list. Staff indicated on the agency's data sharing agreement will be the only staff able to access the information on the list for follow-up.

Health Care Providers/EIS

Health care provider staff will investigate the care status of persons identified on their NIC list using their internal sources. Such sources include, but are not limited to:

- CAREWare (their individual CAREWare contracts in the Part A domain)
- The agency's electronic health records
- Direct contact with clients to determine status

All activities and information collected from data sources (including interviews) must be documented for that respective individual.

Additional Follow-Up by CCBH

After health care provider investigation, if it there are individuals that were never linked to care after diagnosis, were last seen by a non-Part A provider, or were unable to be contacted by a Part A provider, CCBH can step in to follow-up with those individuals.

If CCBH personnel make contact with an individual and determine that an individual is not in care and needs to be linked to care, he/she will provide the individual with provider options in the Cleveland TGA. If the client indicates a particular provider, CCBH staff will provide the individual with the Part A contact info for that agency. CCBH staff will obtain consent from individual to provide their contact info to the provider so that provider can also contact the individual directly. CCBH staff contact info will also be provided to individual for any necessary follow-up. CCBH personnel will also assist HIV-positive individuals with other support services and referrals as necessary.

CCBH Definition of "In Care"

Due to the complexity of client cases, simply relying on HIV lab values may not accurately reflect a client's care status (whether or not a person is actively engaged in HIV care with a healthcare provider and taking medication). When completing a client investigation, a client is considered to be in care if within the prior 365 days from investigation or 365 days from the generation of the NIC list they had one of the following care markers:

a. Viral Load value
b. HIV medical visit
c. Prescription for an anti-retroviral medication

Some clients, while not having one of these care markers, may still be in care if they have the following care marker:

a. Medical case management (MCM) service documented in CAREWare with notes indicating the client has been in care within the previous 365 days from investigation or 365 days from the generation of the NIC list

When there is a documented MCM service, if the medical case manager has a documented viral load in their records within the previous 365 days, this information can be obtained to update NIC list records. In this case, individual is considered "in care". (Please note: if there is no viral load documented by the medical case manager, the individual will be considered "not in care".)

Care Status Dispositions

Upon investigation of each case, a care status disposition must be assigned based on investigation outcome. On the Excel file, this field is named **invest_dispo**. Disposition options are as follows:

1 – Deceased
2 – Resides out of jurisdiction (a different state, not another jurisdiction within Ohio)
3 – In care (please reference definitions of in care in this protocol)
4 – Not in care (confirmed with the individual)
5 – Unable to determine

Follow-Up Investigation of Care Status

The outcome of the linkage/re-engagement attempt must be documented on the NIC list, in the field named **int_dispo**. The field can be assigned one of the following dispositions:

1 - No intervention initiated (program did not offer any linkage or re-engagement intervention to the client)
2 – Linkage/re-engagement intervention declined by client (program offered intervention, but it was declined by client)
3 – Returned to care before intervention was initiated (client entered or resumed care without any additional linkage intervention)
4 – Linkage/re-engagement intervention initiated, not successfully linked to/re-engaged in care (client did not enter or resume care, despite the program's intervention efforts)
5 – Linked to/re-engaged in care, documented (client was linked to/re-engaged in care, confirmed by documented lab results, medical provider report (verbal or written), medical or other record review, other database, ARV prescription filled or refilled)
6 – Linked to/re-engaged in care, client self-report (client was linked to/re-engaged in care, determined by client's self-report)
7 – Linkage/re-engagement status unknown

Linkage or re-engagement is defined as an action taken by the program to facilitate a client's entry or re-entry into HIV medical care (e.g., ARTAS, scheduling the appointment, reminding the client of the

appointment, accompanying the client to their appointment, follow-up to ensure that the appointment took place).
Linked to or re-engaged in care is defined as the client attending an appointment for HIV medical care after having been identified as being NIC.

Expectations

Ohio Department of Health will set the specific timelines with dates for all Data to Care activities based on when NIC lists are sent to local health departments. As timelines are relayed to CCBH, the Part A office will ensure that health care providers are aware of timelines also.

Time Frame Guidelines: The NIC list is a time sensitive document and client investigations should occur as quickly as possible. The following is a timeline of activity which CCBH and Part A providers should adhere to:

Once NIC list is received from ODH, CCBH staff will have approximately two weeks to reconcile ODH's NIC list with their available data sources, and create the agency-specific NIC lists

Part A health care providers will have approximately three months to determine care status of individuals on their NIC list.

In total, this will be four months after CCBH originally received the NIC list from ODH. At this point, CCBH will compile all the updated agency-specific NIC lists into one list that will be sent to ODH.

ODH will be providing a new and updated NIC list approximately every six months. Individuals that were unable to be reached in the four month period will remain on the next NIC list.

(Please note: these timelines and guidelines may change from list to list based on ODH expectations.)

Contact Attempts: All Part A agencies should adhere to the standard clinical practice of making three attempts to reach an individual on the NIC list. Methods of contacting an individual can include phone, email, or texting. After all clients from the NIC list are investigated, clients who were dispositioned as "Unable to Determine" may be reinvestigated.

Data Collection Tools:

The Ohio Department of Health has developed a Data-to-Care Data Collection Tool that can be used to help document data and information. The tool can be found as an appendix to this protocol. (Please note: use of this form is not mandatory, it is a suggested tool that you may find useful while interviewing individuals)

Providing Data Obtained During Investigative and/or Programmatic Activity to ODH

CCBH understands the importance of sharing updated information that was missing or outdated from the preliminary NIC list generated by ODH from eHARS. Updated information (e.g., an individual's

address, telephone number(s), provider name and contact information, recent laboratory results, etc.), as well as the disposition of the care status investigation and linkage to care process, will be shared back with ODH in order to update HIV Surveillance data, create future NIC lists, and identify any HIV data reporting issues.

Security and Confidentiality Considerations

CCBH routinely uses personally identifiable and sensitive information as part its HIV care activities. When following up with HIV-diagnosed individuals who need linkage services, Part A-funded staff must be able to access client locating information, client medical and laboratory information, and provider and facility information. Ensuring that all of this information is managed, stored, and used securely and confidentially is a priority for CCBH. CCBH and its staff are compliant with the Health Insurance Portability and Accountability Act (HIPAA). All Part A providers have contracts with the Cuyahoga County Board of Health, which require them to be HIPAA-compliant.
Data that are collected through the care status investigation process will be securely stored in the NIC list Excel-file that will be password-protected.

The NIC list that will be used as a basis for the care status investigation will be stored in a secure folder on a server maintained by the CCBH IT Department. Only D2C program staff will have access to the folder and the list file. Both the folder and all files within the folder which will be encrypted and password protected.

Monitoring and Evaluation (M&E)

CCBH considers program monitoring and evaluation important activities for improving program performance and outcomes. Activities can include:

- Tracking routine program metrics
- Addressing broader questions about the purpose of D2C in the Cleveland TGA
- Quality assurance process and measures to confirm and improve data accuracy

Program monitoring will include collecting information related to the successes and barriers experienced by staff that generate the NIC list from the surveillance system and/or use the NIC list in the field to locate people.

CCBH personnel will be utilizing Data to Care monitoring and evaluation (M&E) tools developed by NASTAD; specifically the Process and Outcomes Evaluation Tool will used. The evaluation tool is an Excel file where after each NIC list cycle, CCBH personnel will pull aggregate numbers from the master updated Excel file. The tool will be able to calculate process and outcome measures.

The process measures to be calculated and examined will include:

- Percentage who were later found to be in care pre-assignment
- Percentage who were later found to be in care after being assigned
- Percentage who were found to be in care after being contacted
- Percentage found to be in care as part of any D2C activities
- Percentage that were unable to be located
- Percentage Confirmed Out of Jurisdiction (OOJ)
- Percentage assigned for follow-up
- Percentage of assigned that were located
- Percentage cases that were updated in eHARS

The short-term outcome measures to be calculated and examined will include:

- Percentage of NIC individuals that were linked
- Percentage of assigned cases that were linked
- Percentage of located that were linked
- Percentage of located that accepted linkage support
- Percentage accepting linkage support, that were linked
- Percentage of linked who were retained in care 12 months after linkage
- Percentage of linked who are virally suppressed in 12 months after linkage
- Percentage of linked who are NOT virally suppressed in 12 months after linkage

The long-term outcome measures that CCBH staff will examine include:

- Increased access to care, reduced viral load & improved health outcomes for PLWHA
- Reduced HIV-related health disparities
- Higher rates of suppressed community viral load
- Reduced HIV transmission
- Lower HIV incidence
- Enhanced collaboration with providers
- Improved data quality

CCBH will routinely document and share program monitoring with D2C staff at CCBH and with Part A agencies to ensure program success. Health care providers may be conducting their own M&E internally, and we encourage providers to communicate monitoring findings regularly to key staff involved with implementation to improve delivery of services and program implementation. Part A agencies are also encouraged to communicate any M&E findings to CCBH personnel.

M&E findings from the first NIC list will serve as a baseline for the D2C program in the Cleveland TGA. Based on those results, targets and goals can be set for each round of NIC lists released.

Acknowledgments

Thank you to the following for their guidance and assistance in development of this initiative and protocol:

Part A Data to Care Staff, Columbus Public Health
Office of HIV/AIDS, Cleveland Department of Public Health
HIV, STI, & Viral Hepatitis Interventions and Treatment Section, Ohio Department of Health

Sources:

The Ohio Department of Health, Region 3/Ryan White Part A-Cleveland HIV Surveillance Data Tables
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/hiv-aids-surveillance-program/resources/region-3-hiv-surveillance-data-tables

Appendices (can also be found in the ODH protocol)

Appendix B – Data Collection Tool
Appendix C – Data Dictionary for Fields Included in the NIC List
Appendix D - Reporting D2C Variables to ODH-File Layout for required fields to be reported back to ODH

Data-to-Care Data Collection Tool—Fax to HIV Surveillance (614-564-2427)			
State no:	**DOB:** (MM/DD/YYYY)	**Alias:**	
Last Name:	**First Name:**	**M.I.**	
Address Date: (MM/DD/YYYY)	**Phone Number:**		
Street:	**City:**		
County:	**State:**	**Zip:**	
How person was first identified as not in care (invest_ident_method): ☒ 02 – Health department integrated data system	**Date identified as not in care** (invest_ident_dt): 8/1/2019		
Included for investigation (invest_incl)? ☐ Yes ☐ No	**Date investigation opened** (invest_start_dt)**:**		
Disposition, care status investigation (invest_dispo)**:** ☐ 1 – Deceased ☐ 4 – Not in care (confirmed) ☐ 2 – Resides out of jurisdiction (other state) ☐ 5 – Unable to determine ☐ 3 – In care	**Investigation disposition date** (invest_dispo_dt)**:**		
Basis of care status disposition (invest_dispo_dt)**:** ☐ 1 – Database/record search only ☐ 3 – Database/record search and patient contact/field investigation ☐ 2 – Patient contact/field investigation only			
Disposition, linkage or re-engagement intervention (int_dispo)**:** ☐ 1 – No intervention initiated ☐ 2 – Linkage/re-engagement intervention declined by client ☐ 3 – Returned to care before intervention was initiated (enter date) ☐ 4 – Linkage/re-engagement initiated, not successfully linked to/re-engaged in care ☐ 5 – Linked to/re-engaged in care, documented* (enter date) ☐ 6 – Linked to/re-engaged in care, self-report (enter date) ☐ 7 – Linkage/re-engagement status unknown	**Date returned to, linked to, or re-engaged in care** (int_dispo_dt)**:** *Examples of types of documentation: laboratory data, report from medical provider (verbal or written), medical record review, other record review, other database, ARV prescription filled or refilled.		
Updated CD4 information:			
Performing Laboratory:	**Ordering Facility:**	**Ordering Provider:** (last, first)	
Date of specimen collection: (MM/DD/YYYY)	**CD4 Count:**	**CD4 Percent:**	
Updated VL information:			
Performing Laboratory:	**Ordering Facility:**	**Ordering Provider:** (last, first)	
Date of specimen collection: (MM/DD/YYYY)	**VL Result:**		
Additional information:			
Evidence of Care other than CD4/VL: (e.g., ARV use (list specific drug), case management visit, etc.) and source of information (e.g., EMR):	**Date of other care:** (MM/DD/YYYY)		
Barriers (if applicable, list any barriers faced by client that might prevent access to care):			
Referrals (if applicable, select all that apply): ☐ Behavioral Health Services ☐ Health Benefits Navigation and Enrollment ☐ Medication Adherence ☐ Social Services ☐ Other _____			
Comments (Record any additional information (e.g., sex, race/ethnicity, gender, risk (if missing), death date if deceased, etc.)**:**			

Appendix C: Data Dictionary for fields included in the NIC list (i.e., what regions will receive)

Variable Name	Description	Values/Format
RWagency	Ryan White Agency	
lastRWdate	Date of 'last touch' at Ryan White Agency	MM/DD/YYYY
stateno	State patient number	
last_name	Patient's last name	
first_name	Patient's first name	
middle_name	Patient's middle name or initial	
dob	Date of birth	YYYYMMDD Missing = .
cur_age	Patient's age as of date NIC list was generated	In years
birth_sex	The patient's sex at birth	(M)Male (F)Female
current_gender	The patient's current gender identity	(AD) Additional gender identity (F)Female (FM) Transgender—Female to male (M)Male (MF)Transgender—Male to female (U)Unknown
hiv_aids_dt	Earliest date of diagnosis	MM/DD/YY
newrace	The race of the patient	(1)American Indian/Alaska Native (2)Asian/Pacific Islander (3)Black, not Hispanic (4)Hispanic (5)White, not Hispanic (6)Multi-race (9)Unknown
trans_categ	Transmission category This calculated variable represents HIV exposure, based on a group of risk behaviors. The risk factors are grouped by adult and pediatric, based on the patient's age at diagnosis of HIV. The selection of the most likely route of transmission is based on a presumed hierarchical order of transmission.	(01)Adult male sexual cntct male (MSM) (02)Adult injection drug use (IDU) (03)Adult MSM & IDU (04)Adult rcvd clotting factor (05)Adult heterosexual contact (06)Adult rcvd transfusion/transplant (07)Perinatal exposure w/HIV age 13+ yrs (09)Adult no identified risk factor (NIR) (10)Adult no risk factor reported (NRR) (11)Child rcvd clotting factor (12)Perinatal exposure (19)Child no identified risk factor (NIR) (20)Child no risk factor reported (NRR)
dx_status	Diagnostic status	(1)Adult HIV (2)Adult AIDS (4)Pediatric HIV (5)Pediatric AIDS
prison	Prison status	Currently in Prison or blank
cur_street_address1	Street address of current residence	
cur_street_address2	Street address of current residence (line 2)	
cur_city_name	City of current residence	
cur_county_name	County of current residence	
cur_state_cd	State of current residence	
cur_zip_cd	ZIP Code of current residence	99999 999999999
cur_phone	Phone number of current residence	
cur_address_dt	The date the person was known to be living at the current address	YYYYMMDD Missing = .
hf_name1	Name1 of facility at HIV diagnosis	
hf_city_name	City of facility at HIV diagnosis	
hf_state_cd	State of facility at HIV diagnosis	
hf_provider_last_name	Last name of provider at HIV diagnosis	
hf_provider_first_name	First name of provider at HIV diagnosis	
af_name1	Name1 of facility at AIDS diagnosis	
af_city_name	City of facility at AIDS diagnosis	
af_state_cd	State of facility at AIDS diagnosis	
af_provider_last_name	Last name of provider at AIDS diagnosis	
af_provider_first_name	First name of provider at AIDS diagnosis	

Variable Name	Description	Values/Format
cd4_recent_cnt_dt	Date of most recent CD4 count	YYYYMMDD Missing = .
cd4_recent_cnt_value	Value of most recent CD4 count	
cd4_recent_pct_dt	Date of most recent CD4 percent	YYYYMMDD Missing = .
cd4_recent_pct_value	Value of most recent CD4 percent	
cd4cntnotes	Notes or comments regarding the cd4 count (cd4cnt). Provider/Facility information is sometimes included	
cd4cntfacname1	Name1 of facility that ordered the cd4cnt	
cd4cntfaccity	City of facility that ordered the cd4cnt	
cd4cntfacstate	State of facility that ordered the cd4cnt	
cd4cntprovlname	Last name of provider that ordered the cd4cnt	
cd4cntprovfname	First name of provider that ordered the cd4cnt	
cd4pctnotes	Notes or comments regarding the cd4 percent (cd4pct). Provider/Facility information is sometimes included	
cd4pctfacname1	Name1 of facility that ordered the cd4pct	
cd4pctfaccity	City of facility that ordered the cd4pct	
cd4pctfacstate	State of facility that ordered the cd4pct	
cd4pctprovlname	Last name of provider that ordered the cd4pct	
cd4pctprovfname	First name of provider that ordered the cd4pct	
vl_recent_dt	Date of most recent viral load	YYYYMMDD Missing = .
vl_recent_value	Value of most recent viral load	
vlnotes	Notes or comments regarding the viral load (vl). Provider/Facility information is sometimes included	
vlfacname1	Name1 of facility that ordered the vl	
vlfaccity	City of facility that ordered the vl	
vlfacstate	State of facility that ordered the vl	
vlprovlname	Last name of provider that ordered the vl	
vlprovfname	First name of provider that ordered the vl	
If a digit of a date is missing, it is indicated by a '.', even if the other digits are present (e.g., 200905.. when a date is missing but the year and month are known).		

Notes on facility names:

IP = Inpatient
MC = Medical Center
OP = Outpatient
OOS = Out of State
PPCOU = Private Physician, first three letters of County

Appendix D: Reporting D2C Variables to ODH-File Layout for required fields to be reported back to ODH.

Note: Whether regions report information back via the Excel file or faxing paper records, at minimum, the patient's state no (or other identifiers such as last name, first name, and date of birth) must be included to ensure accurate reporting.

D2C variables required by CDC	
Variable Description and Name	**Notes**
How person was first identified as not in care? (invest_ident_method)	02 – Health department integrated data system *Populated by ODH.*
Date first identified as not in care (invest_ident_dt)	MM/DD/YYYY *Populated by ODH as the date the NIC list was generated.*
Included for investigation? (invest_incl)	Y – Included in investigation N – Excluded from investigation *All records should be populated as 'Y' unless prioritization method was used and some records were not investigated.*
Date investigation opened (invest_start_dt)	MM/DD/YYYY *Date the investigation was started for that person.*
Disposition, care status investigation (invest_dispo)	1 – Deceased 2 – Resides out of jurisdiction (a different state, not another jurisdiction within Ohio) 3 – In care (there is evidence that the person in receiving regular HIV care (e.g., lab results, self-report, prescription)) 4 – Not in care (confirmed with the person) 5 – Unable to determine *Result of the investigation. Please note this is **NOT** referring to the disposition of a Field Record initiated by a Disease Intervention Specialist in ODRS, but rather the result of the investigation into the person's care status.*
Investigation disposition date (invest_dispo_dt)	MM/DD/YYYY *Date care status was determined.*
Basis of care status disposition (invest_dispo_method)	1 – Database/record search ONLY 2 – Patient contact/field investigation ONLY 3 – Database/record search AND patient contact/field investigation *How was the care status disposition determined?*

Disposition, linkage or re-engagement intervention (int_dispo)	1 – No intervention initiated (program did not offer any linkage or re-engagement intervention to the client) 2 – Linkage/re-engagement intervention declined by client (program offered intervention, but it was declined by the client) 3 – Returned to care before intervention was initiated (client entered or resumed care without any additional linkage intervention) 4 – Linkage/re-engagement intervention initiated, not successfully linked to/re-engaged in care (client did not enter or resume care, despite the program's intervention efforts) 5 – Linked to/re-engaged in care, documented (client was linked to/re-engaged in care, confirmed by documented lab results, medical provider report (verbal or written), medical or other record review, other database, ARV prescription filled of refilled) 6 – Linked to/re-engaged in care, client self-report (client was linked to/re-engaged in care, determined by client's self-report) 7 – Linkage/re-engagement status unknown *The outcome of the linkage/re-engagement attempt. Linkage or re-engagement is defined as an action taken by the program to facilitate a client's entry or re-entry into HIV medical care (e.g., ARTAS, scheduling the appointment, reminding the client of the appointment, accompanying the client to their appointment, follow-up to ensure that the appointment took place). Linked to or re-engaged in care is defined as the client attending an appointment for HIV medical care after having been identified as being NIC.*
Date returned to, linked to, or re-engaged in care (int_dispo_dt)	MM/DD/YYYY *If linkage/re-engagement was confirmed: Date of documented evidence that client attended an HIV medical care appointment, received a lab test, or had ARV prescription filled or refilled.* *If linkage/re-engagement was determined by client self-report: Date client reports having attended an HIV medical care appointment.*
D2C variables required by ODH	
alias	*Alias name of client*
address_date	MM/DD/YYYY Current address as of date
telephone	*Current phone number*
street	*Current street address of residence*
city	*Current city of residence*
county	*Current county of residence*
state	*Current state of residence*
zip	*Current zip of residence*
labcd4	*Laboratory that performed the CD4 test*
facilitycd4	*Ordering facility of CD4 test*
providercd4	*Ordering provider (last, first) of CD4 test*
collectdtcd4	MM/DD/YYYY *Date of specimen collection of CD4 test*
cd4county	*CD4 count result*
cd4percent	*CD4 percent result*
labvl	*Laboratory that performed the VL test*
facilityvl	*Ordering facility of VL test*

providervl	*Ordering provider (last, first) of VL test*
collectdtvl	*MM/DD/YYYY* *Date of specimen collection of VL test*
viralloadresult	*VL result*
othercare	*Evidence of care other than CD4/VL (ART use (list specific drug), case management visit, etc.) and source of information*
othercaredate	MM/DD/YYYY *Date of evidence of care other than CD4/VL*
barriers	*List any barriers faced by client that might prevent access to care (if applicable)*
refbehhlth	Y – Referred for Behavioral Health Services N – Not Referred for Behavioral Health Services *If applicable*
refhlthben	Y – Referred for Health Benefits Navigation and Enrollment N – Not Referred for Health Benefits Navigation and Enrollment *If applicable*
refmedad	Y – Referred for Medication Adherence N – Not Referred for Medication Adherence *If applicable*
refsocserv	Y – Referred for Social Services N – Not Referred for Social Services *If applicable*
refother	Y – Referred for Other Services N – Not Referred for Other Services *If applicable*
comments	Record any additional information (e.g., sex, race/ethnicity, gender, risk (if missing), death date if deceased, etc.)

CLEVELAND TGA CAREWARE USER MANUAL

2020

TABLE OF CONTENTS

INTRODUCTION

Who Was Ryan White?

Ryan White and his mom courageously fought AIDS-related discrimination and helped educate the Nation about his disease.

Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White Ginder fought for his right to attend school, gaining international attention as a voice of reason about HIV/AIDS. At the age of 18, Ryan White died on April 8, 1990, just months before Congress passed the AIDS bill that bears his name – the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act.

About the Ryan White HIV/AIDS Program (RWHAP)

The Ryan White HIV/AIDS Program provides HIV-related services for those who do not have sufficient health care coverage or financial resources to cope with HIV disease. The program is federally funded through the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Annually, the Ryan White HIV/AIDS Program serves an estimated 533,036 individuals living with HIV/AIDS throughout the United States. In 1996, HRSA first designated the six county Cleveland Region as a Part A Transitional Grant Area (TGA).

25 YEARS
Ryan White
HIV/AIDS Program
Moving Forward with CARE:
Building on 25 years of Passion, Purpose and Excellence

The Cuyahoga County Board of Health (CCBH) serves as the Administrator of the Cleveland TGA grant which serves the following Ohio Counties:

- Cuyahoga
- Ashtabula
- Geauga
- Lake
- Lorain
- Medina.

According to the Ohio Department of Health, in 2018 there were a total of 5,857 individuals living with HIV/AIDS throughout the TGA. The Cleveland TGA Part A program provided care and support services to a total of 2,911 individuals in 2018, or 50% of the region's total population living with HIV/AIDS.

Federal Reporting Requirements

As a condition of the grant awards, Ryan White HIV/AIDS Program (RWHAP) recipients are required to report data on clients, services provided, and expenditures.

What kind of data is collected?

Previously, the HIV/AIDS Bureau (HAB) required all RWHAP-funded recipients and the contracted service providers (or "sub-recipients") to report aggregate data annually using the RWHAP Annual Data Report (RDR). However, aggregate data are limited in two ways:

1. Aggregate data lack client identifiers and, by definition, cannot be merged and unduplicated across providers within a given geographic area. As a result, recipients—and ultimately HAB—cannot obtain accurate counts of the number of people RWHAP serves.

2. Aggregate data cannot be analyzed in the detail required to assess quality of care or to sufficiently account for the use of RWHAP funds.

What is client-level data?

To address the barriers with aggregate data, in 2009 HAB started to require all recipients use a new data reporting system called the Ryan White HIV/AIDS Program Services Report (RSR). HAB's goal was to have a client-level data reporting system that provides data on the characteristics of the funded recipients, their providers, and the clients served.

The data submitted through the RSR will be used to do the following:

- Monitor the outcomes achieved on behalf of HIV/AIDS clients and their affected families receiving care and treatment through RWHAP recipients and/or providers;

- Address the disproportionate impact of HIV in communities of color by assessing organizational capacity and service utilization in minority communities;

- Monitor the use of RWHAP for appropriately addressing the HIV/AIDS epidemic in the United States;

- Address the needs and concerns of Congress and the Department of Health and Human Services (HHS) concerning the HIV/AIDS epidemic and RWHAP; and

- Monitor progress toward achieving the goals identified in the National HIV/AIDS Strategy.

HAB has taken every measure possible, including the implementation and use of an encrypted Unique Client Identifier (eUCI), to limit data collection to only the information that is "reasonably necessary to accomplish the purpose" of the RSR.

Client-level data must be submitted for all providers who used RWHAP funds to provide core medical or support services directly to clients during the reporting period.

HAB also understands how important the data reported can be to each RWHAP as each assesses its client service needs and establishes practical outcome measures for its programs. HAB considers these data the property of the grantee and will not share the data with other grantees without the permission of the reporting grantee.

What is CAREWare?

CAREWare is free, HRSA sponsored software used to manage and monitor HIV clinical and supportive care as well as produce federally required service reports. CAREWare is updated regularly to be compliant with HAB reporting requirements. The software is scalable and can be customized to meet local needs.

CAREWare was originally released at a Grantee (Recipient) Meeting in 2000. Usage has increased steadily each year and today over 800 Ryan White-funded agencies in 48 States, Puerto Rico, and the U.S. Virgin Islands use the software to manage their HIV/AIDS information.

CAREWare on a local level

The Cleveland TGA began using the CAREWare data collection system in 2011. The Cleveland TGA CAREWare database is hosted on our own secure server and meets all federal, state and local privacy standards. All Cleveland TGA sub-recipients are required to enter data using the CAREWare system. Due to changes in HRSA/HAB reporting requirements and availability of new features or modules, the Cleveland TGA CAREWare software is typically updated every 6-8 months. Only clients that meet out TGA's eligibility requirements should be entered into the Cleveland TGA's CAREWare system.

Cleveland CAREWare User Manual Appendices

Please reference **Appendix A** for the current instructions to access CAREWare from your internet browser. Keep in mind that the approved web-browsers for CW6 are: Microsoft Edge, Google Chrome, Firefox, and Safari. Note: Microsoft Internet Explorer will not work with CW6. **Appendix B** provides instructions if a user account is locked out and needs to reset their password.

Appendix C and **Appendix D** outline the specific requirements for client level data entry. Standards have been developed for the Cleveland CAREWare server to ensure that all users are entering client-level data in a consistent manner. This simplifies data-entry for all funded providers and helps reduce duplicate client records in CAREWare.

In 2015, the Cleveland TGA began requiring that all sub-recipients upload client eligibility applications and verification documents to individual records using the CAREWare database. Electronic Eligibility instructions are outlined in **Appendix E**. Maintaining shared eligibility documents in CAREWare streamlines the eligibility process throughout the region.

The Cleveland TGA also uses customized built-in CAREWare Data Quality Reports outlined in **Appendix F**. Using these customized reports, agencies can quickly identify and correct missing client-level data. This enables funded sub-recipients to maintain high data quality standards throughout the reporting year.

As mentioned above, as a condition of award of Ryan White funds, HRSA/HAB requires that each funded provider submit their own annual RSR Provider Report. The RSR TIP Sheet outlined in **Appendix G** was developed as a reference for program staff that are responsible for submitting the RSR for their agency and is updated annually.

Each service category in the Cleveland TGA has certain client-level data elements required within CAREWare. These elements are outlined in **Appendix H.**

In 2014, the Cleveland TGA also began collecting billing information through CAREWare. Through this addition, providers no longer have to maintain separate spreadsheets with billing notations, instead contracts are set up in CAREWare to either default to a pre-negotiated rate or are adjusted so that the provider can enter the dollar amount associated with the services themselves. CAREWare billing instructions are included in **Appendix I** and are also updated annually.

Appendix J includes federal and local CAREWare and data reporting resources.

As resources are updated or new information is released, an updated Cleveland TGA CAREWare Manual will be distributed to your agency and an electronic copy will be posted on the Cleveland TGA Provider website. Please make sure that you maintain the most recent CAREWare manual resources at your agency.

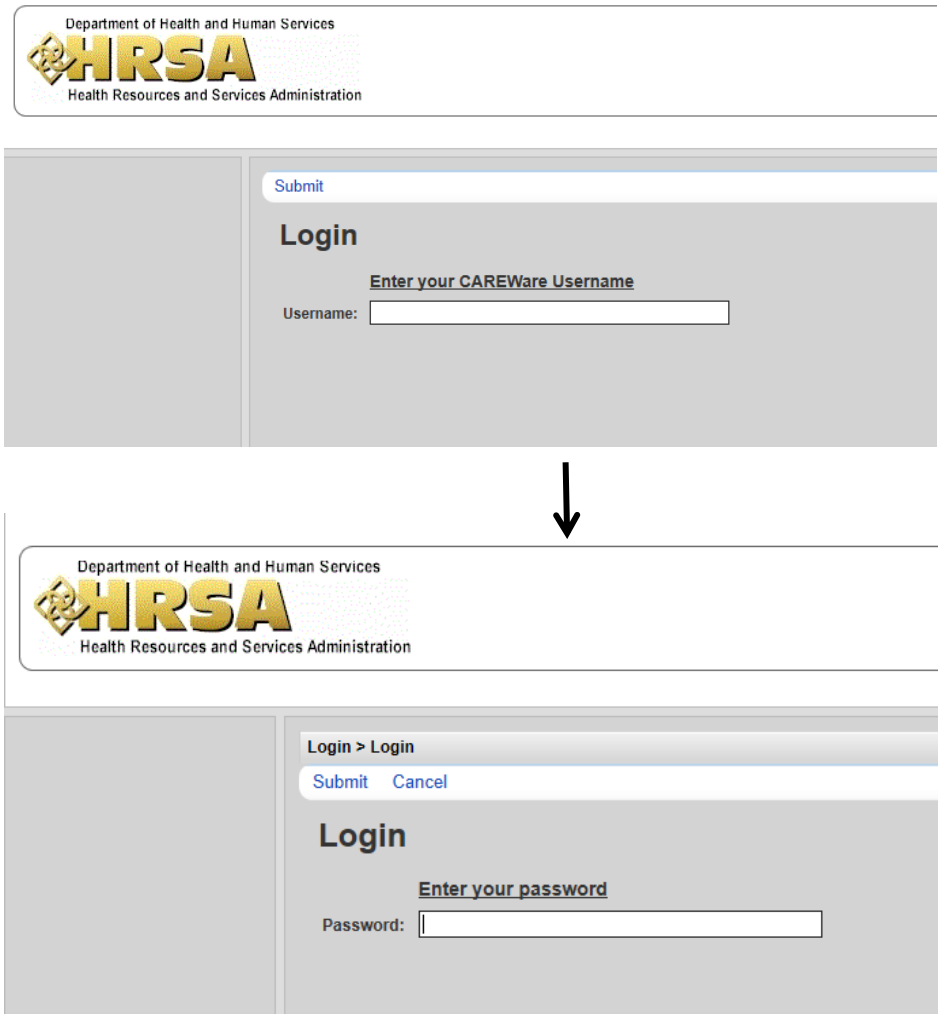
APPENDIX A – CAREWARE ACCESS

CAREWare 6.0 is a web-based system, thus no installation is needed. One can simply access CAREWare 6.0 by entering the following web address into your internet browser (the approved web-browsers for CW6 are Microsoft Edge, Google Chrome, Firefox, and Safari; Microsoft Internet Explorer will not work with CW6):

Recommended to use the Google Chrome browser.

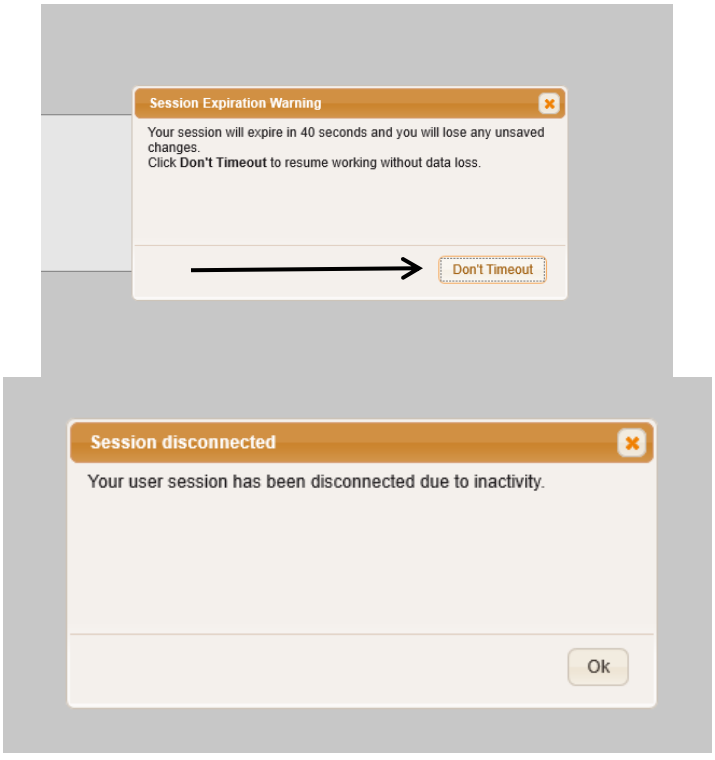
https://carewarecl.ixn.com

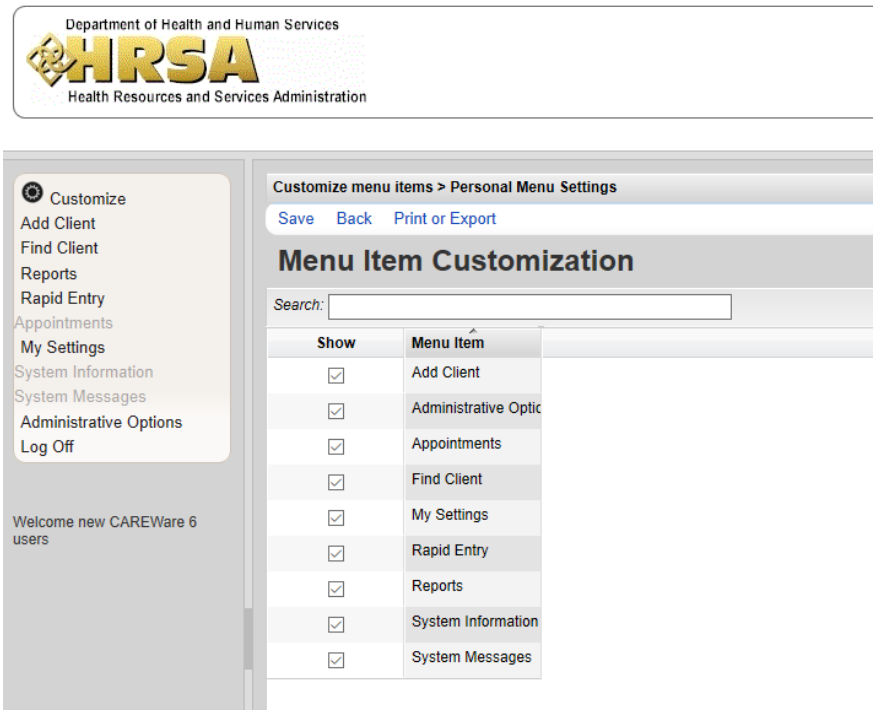
The first step to access CAREWare is to enter your username and password into the login page:



After entering your login and password, the first screen you will encounter is the following:

From this screen, take note of the navigation pane on the far left. From this, one can access the many functions used in CAREWare just as before (i.e. add/find client, reports, settings, etc.) NOTE: if you remain inactive (not using or interacting with CAREWare) for an extended period of time, the site will automatically sign you out due to inactivity.



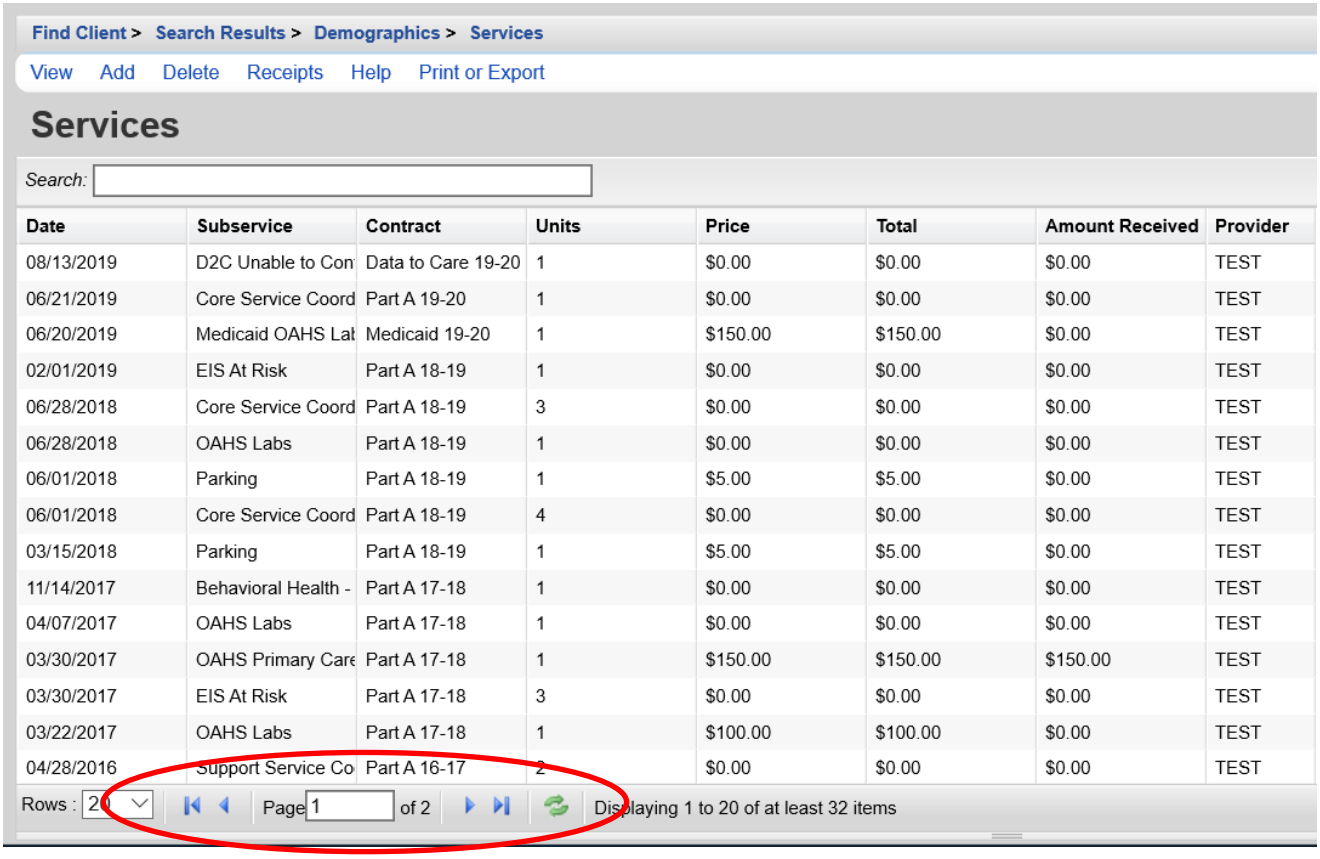


The list of functions on the far left navigation pane can be customized to the user's preference.

Notice the check boxes next to each "Menu Item". One can choose to show (or not show) a menu item by checking (or unchecking) the corresponding box. Be sure to **save** your preferences before navigating away from this screen.

If you cannot see the full text in any column (in the image above, one can see that "Administrative Options" is cut off), you can expand the column by selecting the right margin of a column header and dragging it to the right.

Menus only allow for 20 rows of information/items *per page*. Thus, you must use the navigation buttons at the bottom to view more information/services/menu items. For example, "this client had more than 20 services—to see the rest of the services, you must utilize the bottom navigation buttons to view additional services over the 20 listed here.



NOTE: Use the navigation buttons that appear on the action bar (Save, Back, Cancel, etc.) or the navigation buttons at the bottom of the screen (rows, page, skip to next page etc.), DO NOT use the forward/back buttons on your internet browser. Further, if you edit any information, make sure to SAVE before navigating away from that screen.

APPENDIX B – ACCOUNT PASSWORD RESET

Each user now manages their own CAREWare account. There is no need to contact the Ryan White program office or contractor to 'unlock' your user account. (CAREWare does not keep any historical record of previous user passwords, so you can use the same password indefinitely for CAREWare.)

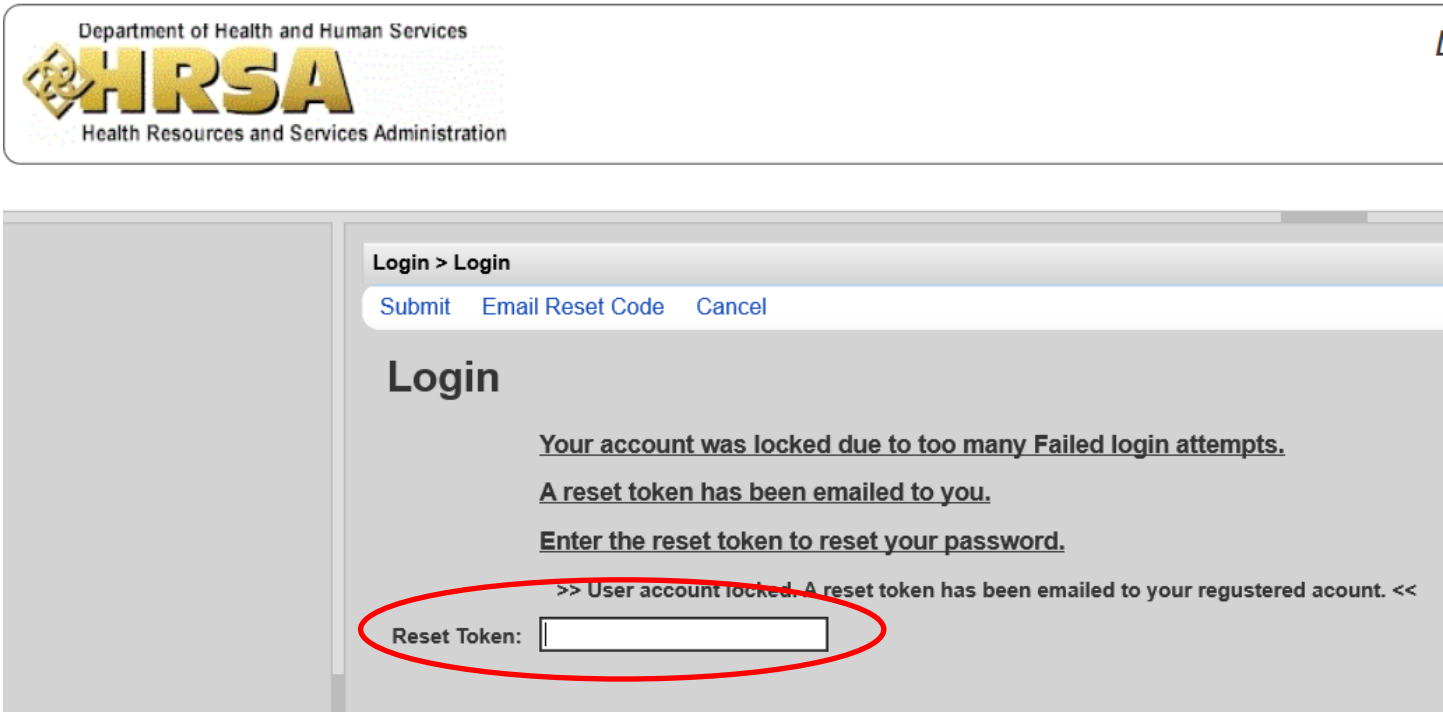
Should you forget your password or your CAREWare account becomes locked, follow these steps with the 'Change My Password' feature in CAREWare (note: you can intentionally lock your account by entering an incorrect password three times in CAREWare).

DISCLAIMER: passwords will expire and need to be reset if a CW user does not login for 6 months/180 days. That being said, the password only needs to be changed for the next login. Once this reset is complete, one may go to settings to change their password back to what it was before the expiration.

Reset password when CAREWare account is locked:

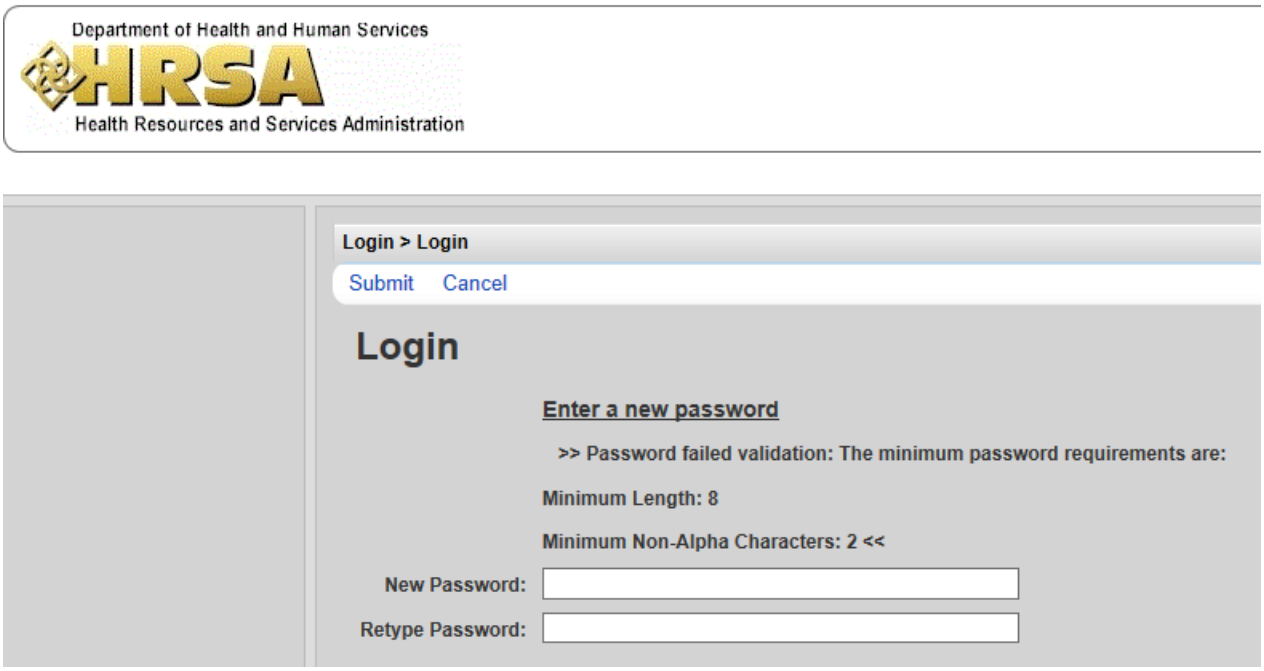
After three (3) failed login attempts, CAREWare 6 will bring you to the following screen in addition to you receiving an email with password reset instructions:

Note: User account has to be locked in order to see the reset prompt screen.



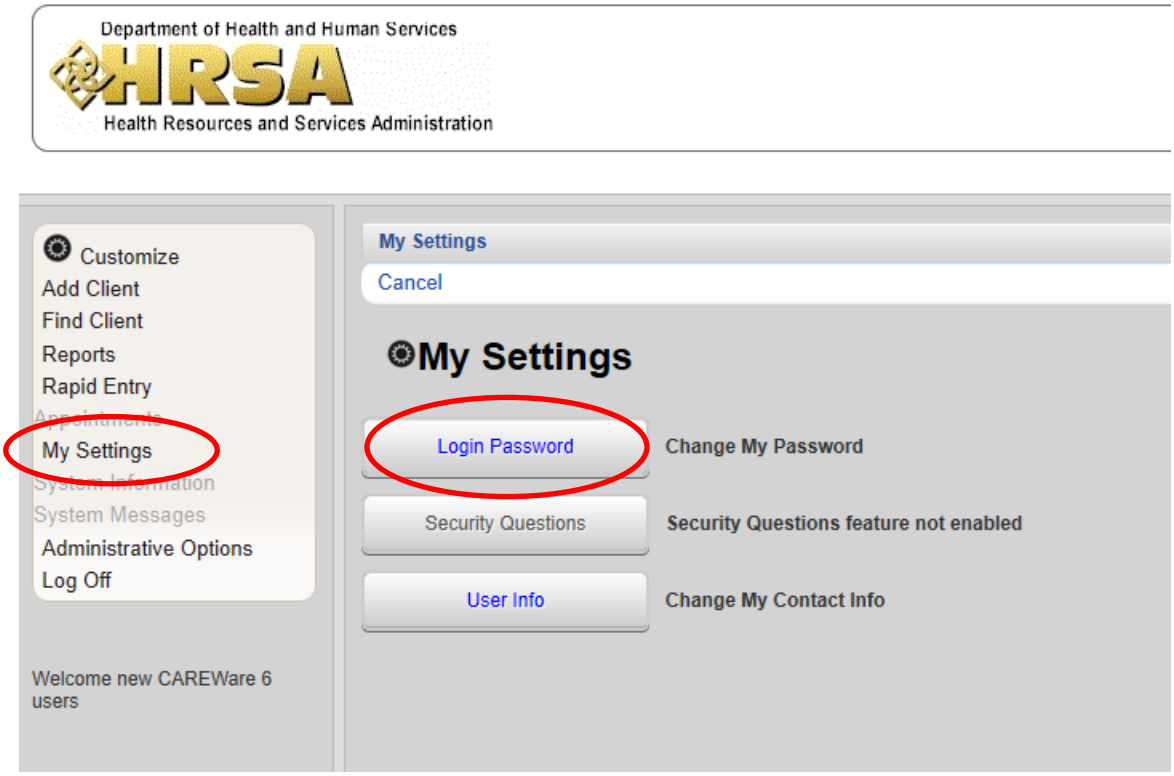
The "token" is an alphanumeric code which you will receive in an email from the CAREWare server (you can resend this email code with the **Email Reset Code** option). Enter this token into the **Reset Token** field to be able to once again access your account. **NOTE:** this token is only available for 1 hour.

After entering your token, you will be brought to the following screen from which you will change your password:

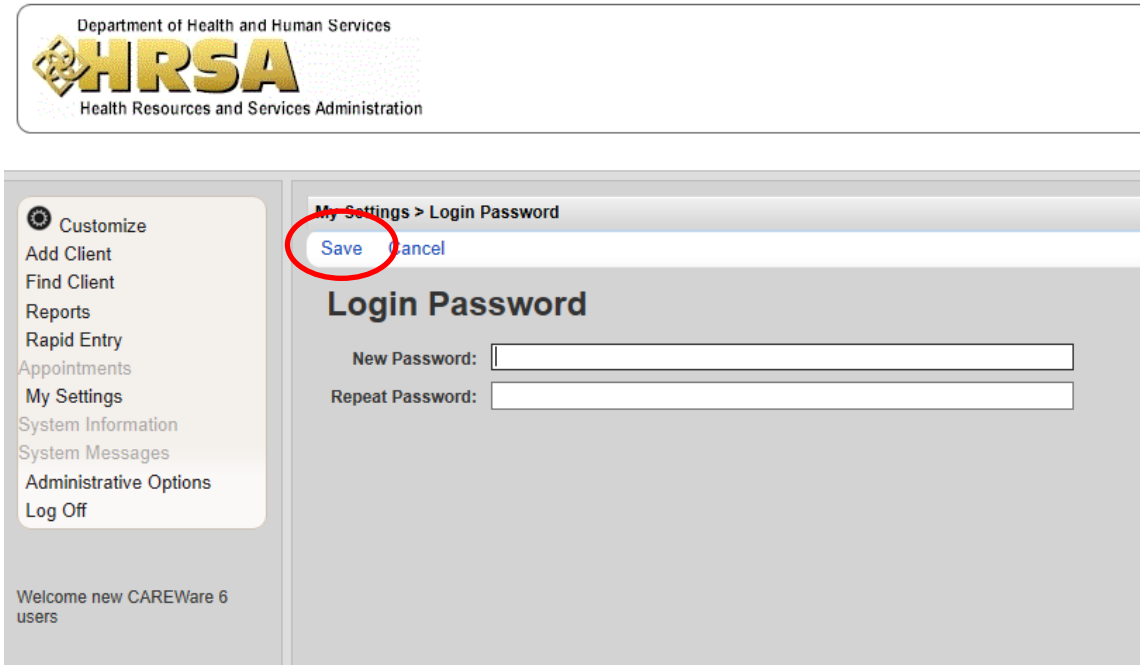


Change your password when already logged in to CAREWare 6:

Click on **My Settings** from the selection menu on the far left of the screen. This will bring you to the following:



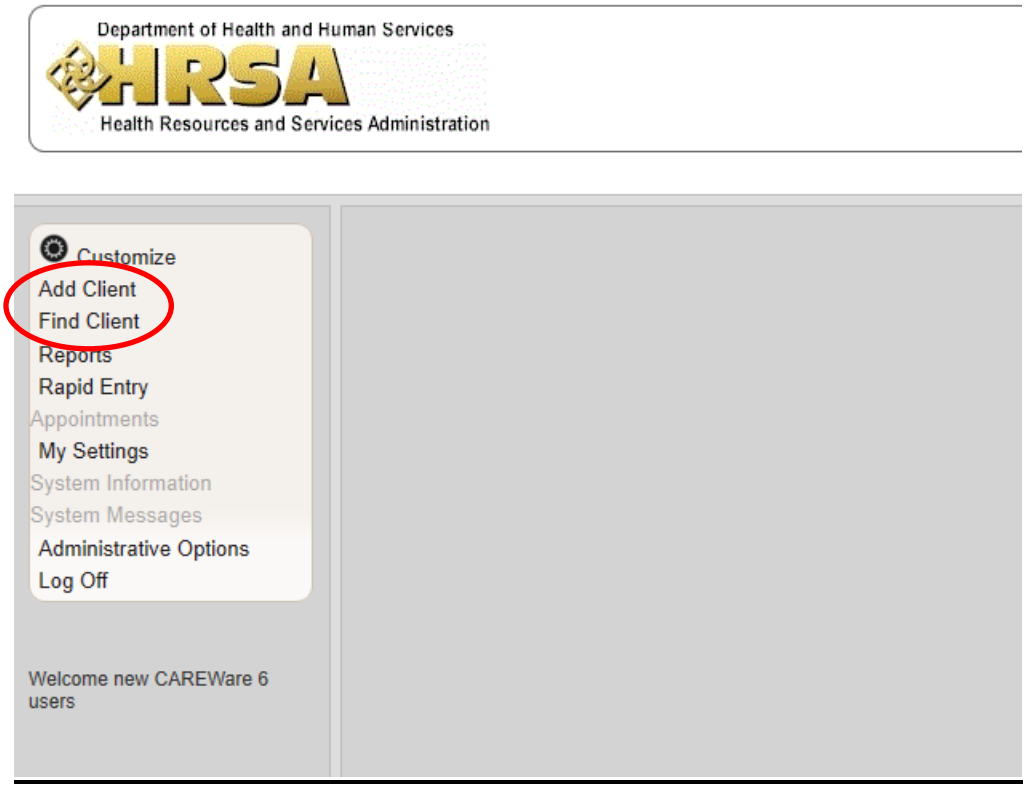
Select the blue hyperlinked **Login Password** to change your password. In the next screen you will enter your new password.



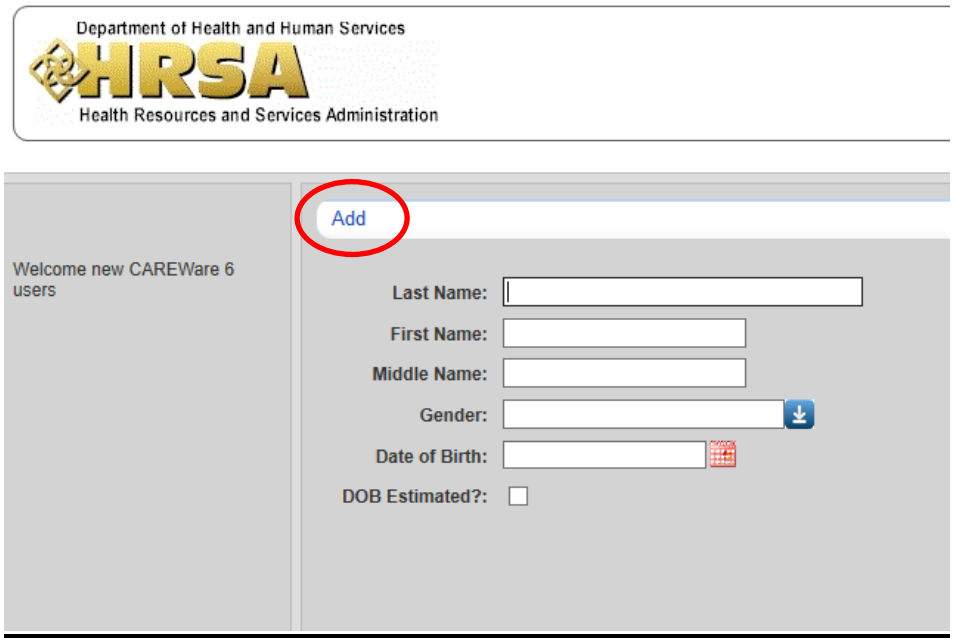
Note: Make sure to click **Save** (above where it says "Login Password" and is in blue) before navigating elsewhere on the site—otherwise the new password will NOT be saved.

APPENDIX C – DATA ENTRY

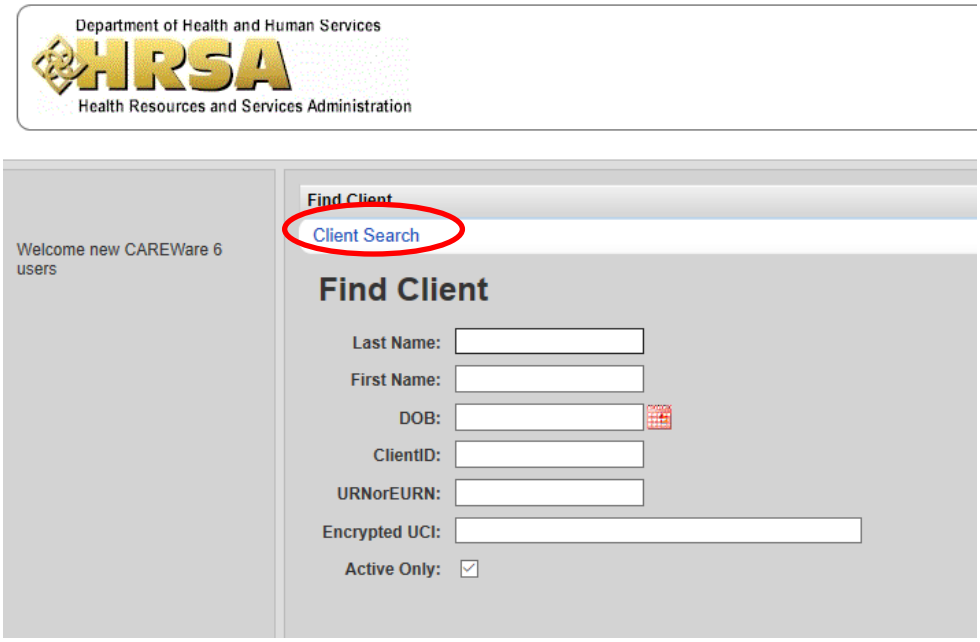
To add a client or view a client, use the navigation pane on the far left.



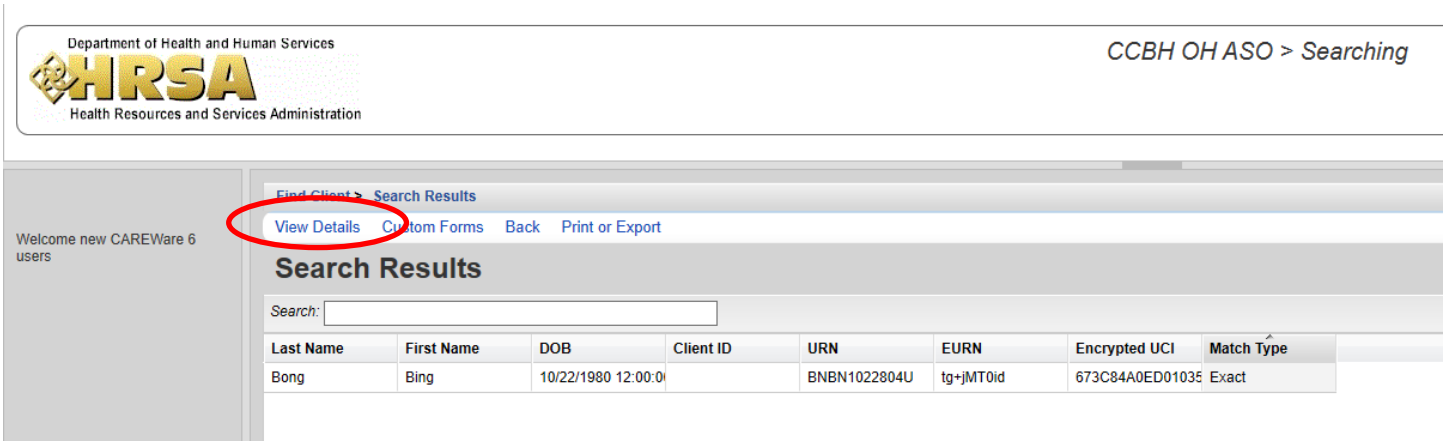
To add a client, select **Add Client**—this will bring you to the following screen in which you will enter the appropriate information and then hit the blue **Add. CAREWare may prompt you if a similar client record already exists.**



Finding a client is done in the same way—select **Find Client** from the navigation pane which will bring you to the following search parameters screen.



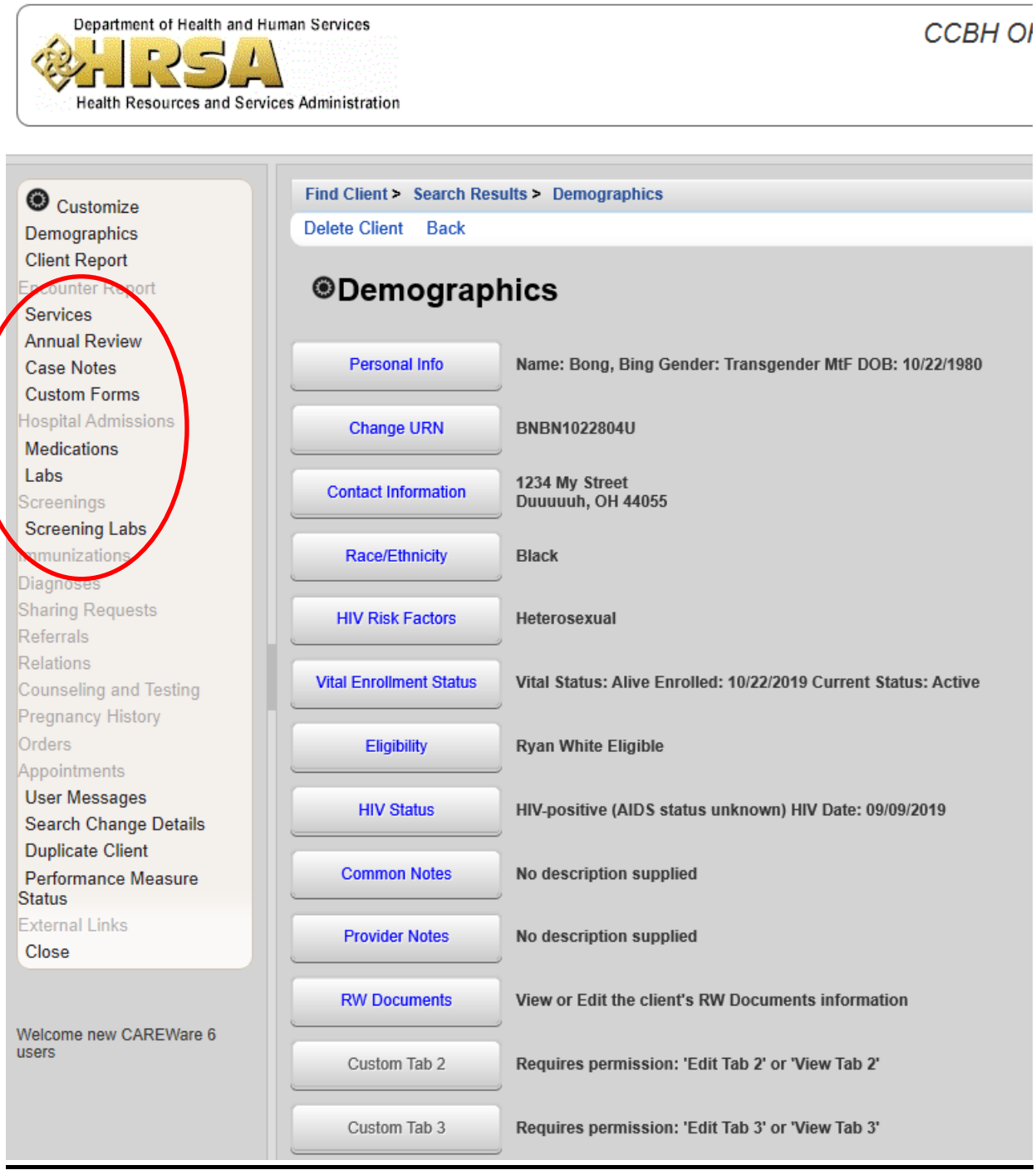
After filling in the search parameters, click on **Client Search**, to initiate the search. The search results will display as follows:



Either double-click the client name, or select the client and hit "view details" to open the client file (the client listed above is a sample client). The client record will open in a separate tab in your browser. This way, you will still be able to access the home screen and functions such as "Reports" or "add/find client" since it is in a separate tab.

Upon opening the client record, you will first encounter the **Demographics** screen. From this point, you can navigate freely using the far left navigation pane to see the client's information (e.g. Medications, Screening Labs, Services, Referrals, Appointments, etc.).

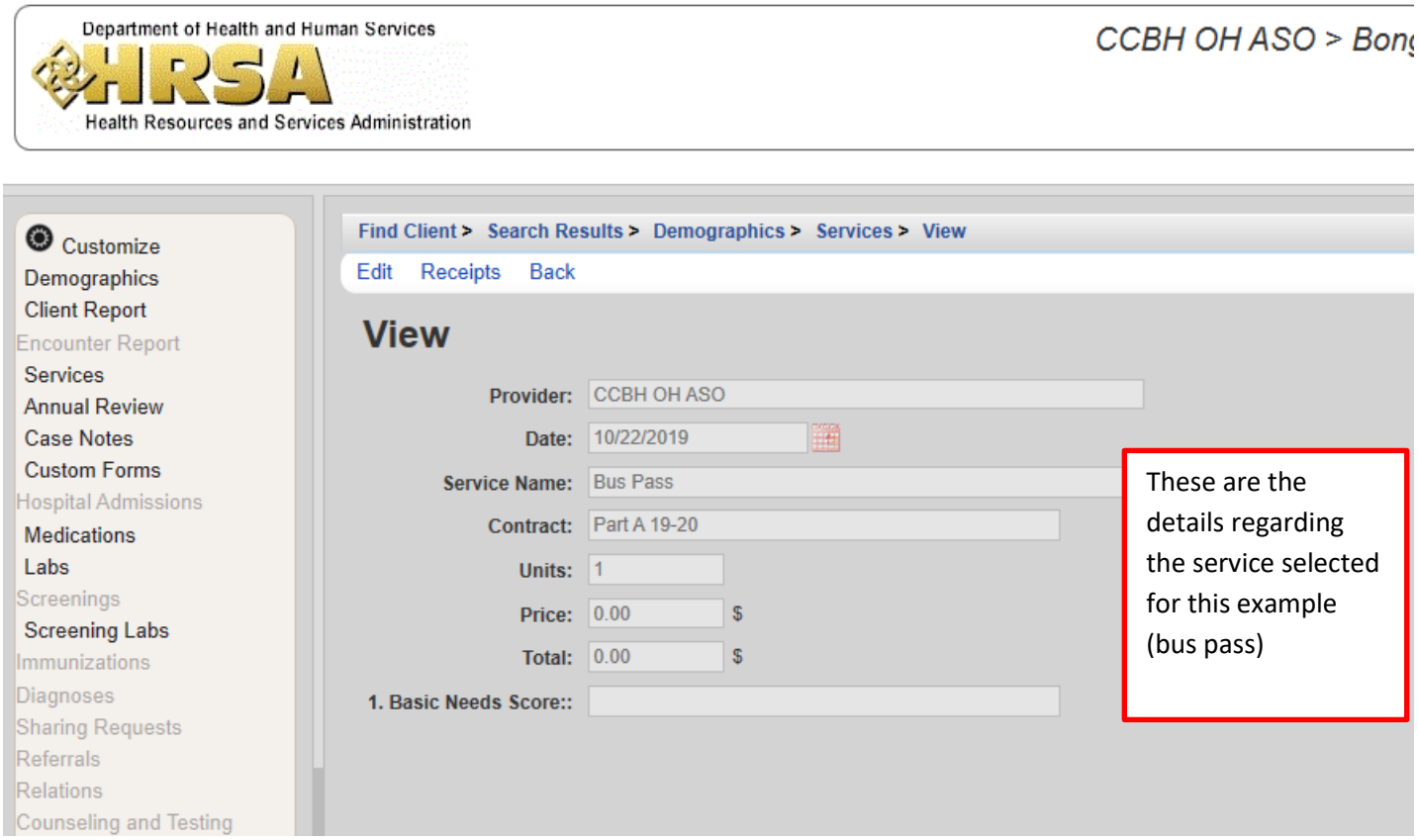
Demographics



Services

From this menu, all services delivered are listed. One can view, add/delete a service, see the receipt for the service, and print/export. One can view the details of a service, either by selecting the service and selecting "view" from the hyperlink above "Services", or by double-clicking the service.

Note: After initial service entry the Service Date and Service Name cannot be changed.

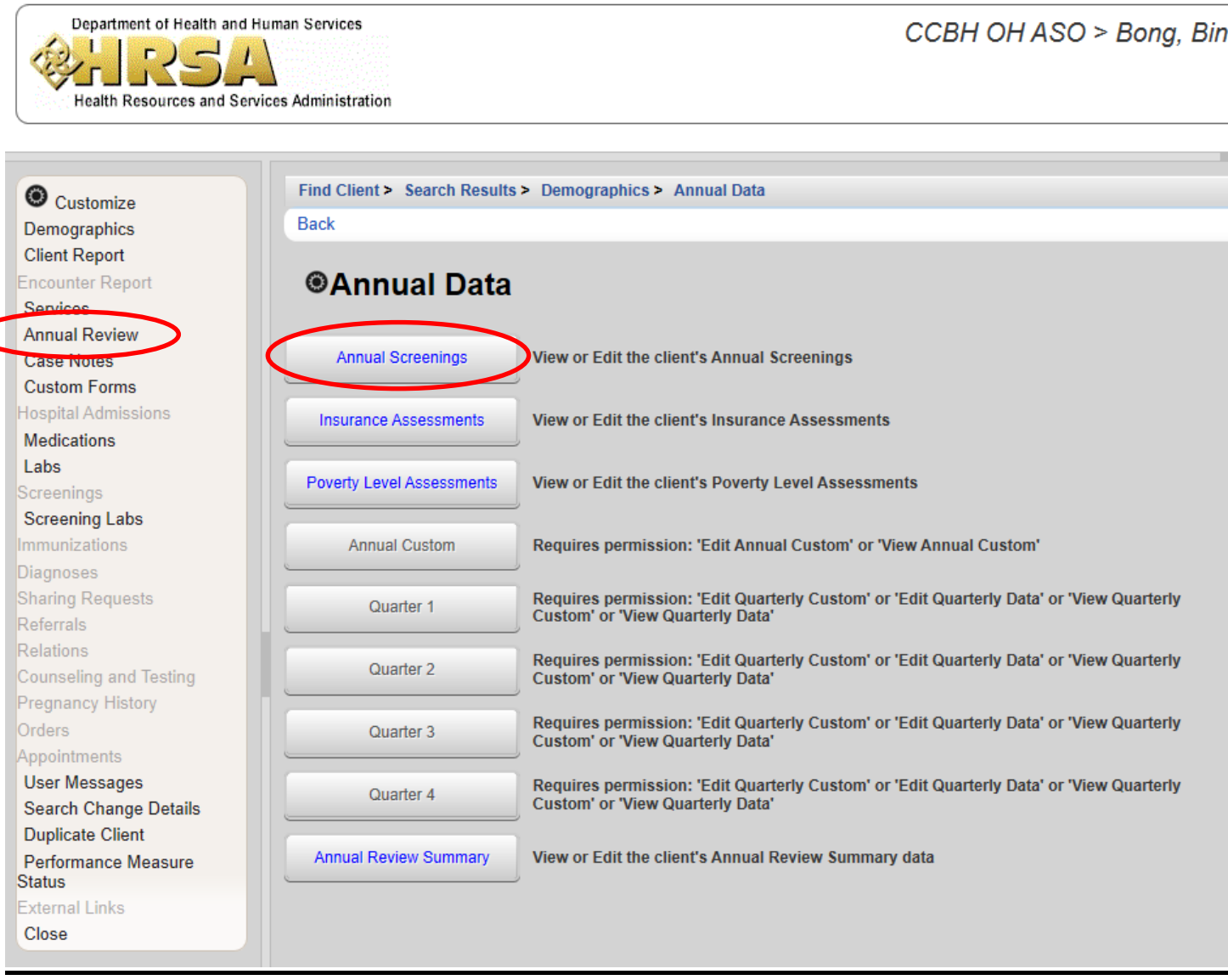


Annual Review

Annual Review, just like the other functions, can be found on the far left navigation pane after a client record is selected. Each of the subsections (Annual Screenings, Insurance Assessments, Poverty Level Assessments, etc.) can be clicked to view or edit the details.

.

All Providers are required to report Annual Screenings, Insurance Assessments, Poverty Level Assessments, whenever any client service is delivered at the start of each calendar year.



APPENDIX D – DATA ENTRY TIP SHEET

CAREWare Data Entry TIP Sheet

1. Only enter new clients into CAREWare after the initial intake or first client service has been completed at your agency. Work from left to right as you click on the tabs in RW CAREWare; *__Demographics__, __Service__, and __Annual Review__, completing *ALL* required fields and dropdowns.

*** *Enrollment Date*** needs to be entered for new clients and **RW Eligibility History** added/updated for all clients!

2. Determine the legal name and exact date of birth (do not estimate birth date) and gender of client from approved federal, state, and/or legal ID (driver's license, birth certificate, etc.). *These fields are critical to the generation of the Unique Record Number (URN)* and if incorrect, it creates duplicate client records in CAREWare.

> ***Note:** If there is a change in the legal name and/or gender for an existing client, update the information in the **existing client record**. Do not create a new client record, as this causes duplicate clients records.

3. When entering compound or hyphenated names, do not leave any spaces or use apostrophes. For example: *William O'Connor, Jr*. should be entered as: Last Name: **OConnor Jr** list surname(s) afterwards, First Name: **William**. Addresses should use the same format, **123 N Main St Apt 3** *without* punctuation, with abbreviations used by the United States Postal Service website: https://tools.usps.com/go/ZipLookupAction!input.action

4. Remember to enter **both** *Ethnicity* and *Hispanic Subgroup,* **and** *Race and Race Subgroup, when applicable*, as these entries are treated as separate and required fields—remember not to leave either section 'Blank'.

5. The *Enrollment Date* (mm/dd/yyyy) should be the client's First service (Intake) at your agency. A *Case Closed Date* is required anytime the *Enrollment Status* is reported differently than '**Active**'. If the *Vital Status* is reported as '**Deceased**', a *Date of Death* is also required.

6. When reporting the *HIV Status*: be sure to fill in the corresponding *HIV+ Date* **and** *AIDS Date*, as applicable. When selecting the *HIV Risk Factor(s):* this refers to client's current risk factor(s) for HIV infection, which may not necessarily be the initial mode of HIV infection.

7. Remember to complete all sections under the Annual Review tab, including, **Insurance** and **Federal Poverty Level**. (For clients with no income, enter zero (0) in the Household Income field, CAREWare auto-fills the dollar sign and decimals, to show $0.00; and will calculate the Poverty Level Percent (%), once the household size is entered.)

8. The only Annual Screening that is required is **Housing Arrangement**; Annual Review information should be verified every six (6) months for recertification, specifically **Income** and Medical **Insurance**. If there are no changes, the 'Bring Forward' feature may be used.

9. It is highly recommended to schedule regular time throughout the week and month, to enter and correct client-level data in CAREWare and avoid waiting until the last day of the month.

10. **IMPORTANT:** First correct the **TLSMissingRyanWhiteEligibility** report, then the **RSR Client Report Viewer** correcting all *Missing* and *Unknown* values, and remaining **TLS Missing** data reports until *'No records were found. The report will not be displayed.'* for each custom missing data report – prior to submitting monthly agency reimbursement requests.

Have Program Questions? Regarding contracted funded services, unit rates, or reimbursement requests? Please contact the Ryan White Part A program office at (216) 201-2001 or visit: www.ccbh.net/ryan-white

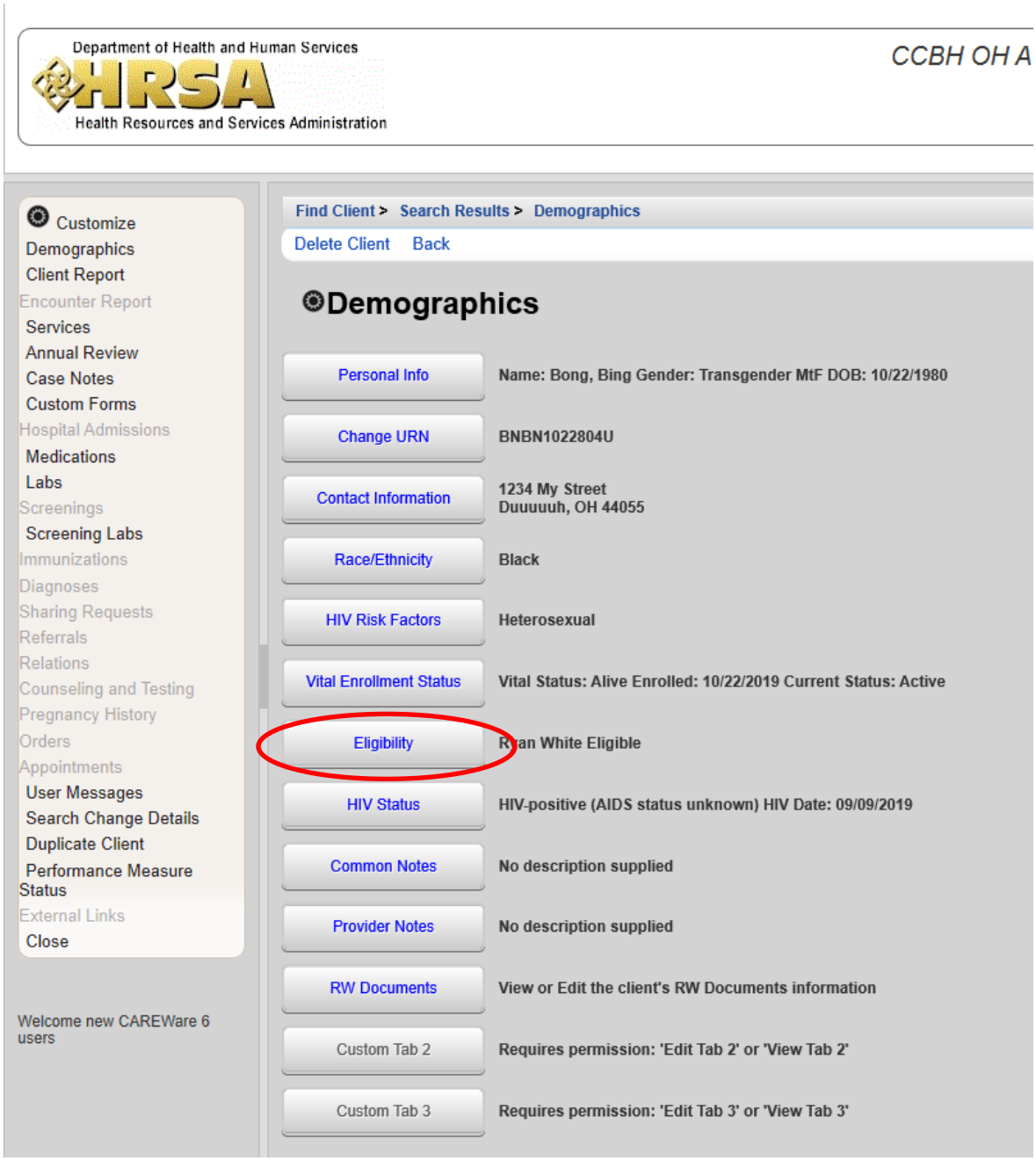
Need Help with CAREWare or Technical Assistance?

Please contact the Ryan White program office at (216) 201-2001.

JAN 2020 REV PB

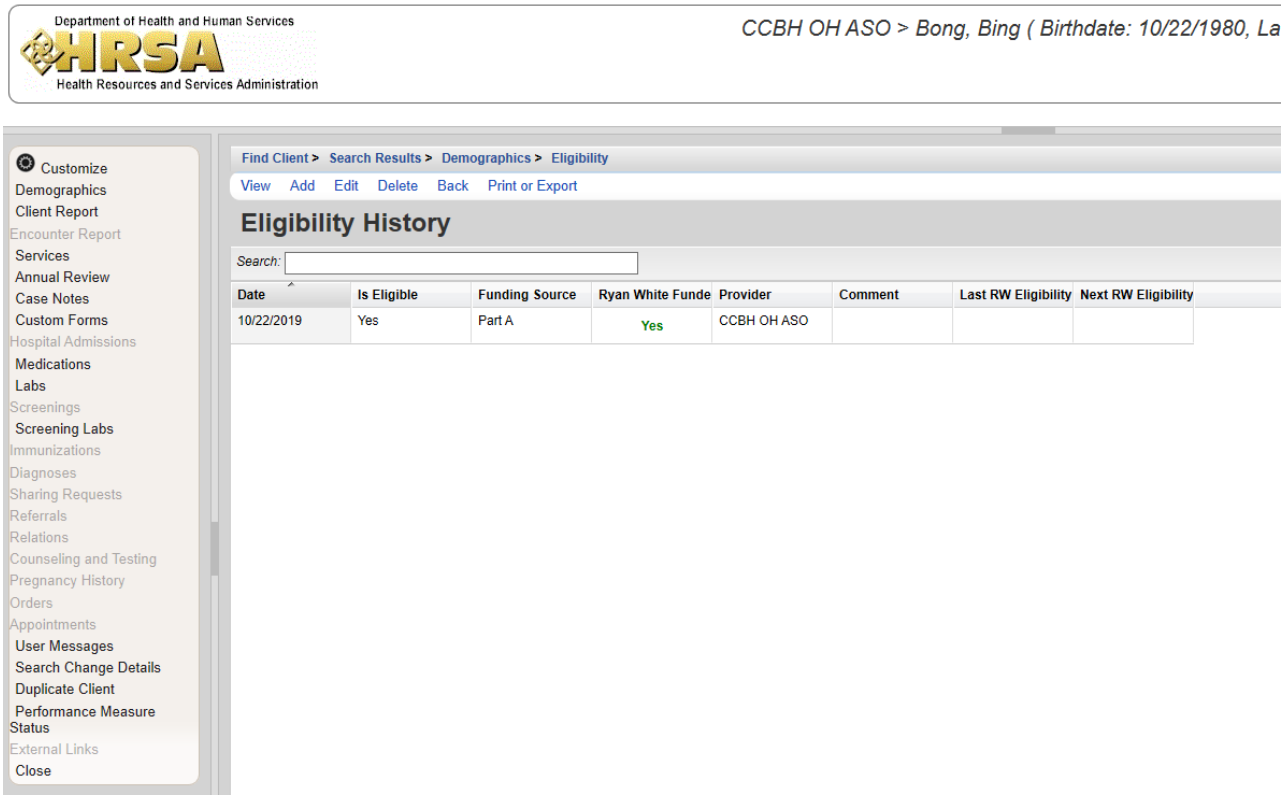
APPENDIX E – ELECTRONIC ELIGIBILITY

Electronic Eligibility is the centralized storage of all Ryan White Part A client eligibility documents in the CAREWare database. To accomplish this, provider agencies upload eligibility documents in the **Eligibility** link in individual client CAREWare records. The eligibility link is in the shared domain, meaning every agency serving the client can view the uploaded documents. Eligibility can be found on the **demographics** page.



Upon selecting the eligibility link, you will be brought to the “Eligibility History”. You can double click any eligibility entry to view and/or edit its details.

Note: Ensure RW-eligibility is determined before services are entered.



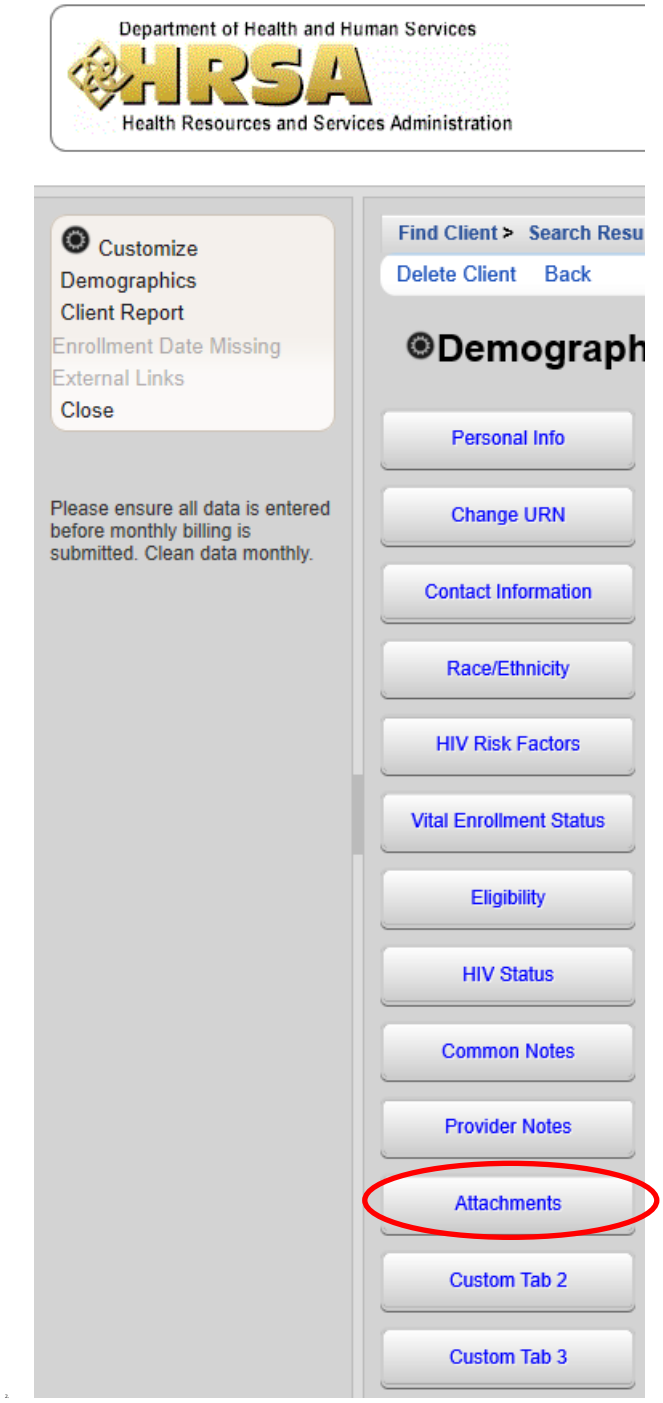
Getting Started:

1. Prior to upload, each eligibility document must be assigned the correct file name:
    - In assigning the file name, the Eligibility Document Type[1] determines the File Name Format[2] used.
      The client eligibility date, located on the Eligibility Application or Six-Month Recertification Form, is used to populate (mm dd yy) in the file name.
        Note: The value of (mm dd yy) in the file names of an eligibility application and every document supporting it, such as Proof of Income, will be identical.
    - Each Eligibility Document Type is assigned a corresponding Custom Attachment Field[3] to which it will be uploaded.

Eligibility Document Type[1]	**File Name Format[2] mm dd yy = Eligibility Date**	**Custom Attachment Field[3]**
Eligibility Application	mm dd yy APP	Eligibility Application
Proof of Residency	mm dd yy RES	Proof of Residency
Proof of Income	mm dd yy POI	Proof of Income
Proof of HIV Status	mm dd yy HIV	Proof of HIV Status
Proof of Insurance Status	mm dd yy INS	Proof of Insurance Status
Six Month Recertification- No Change	mm dd yy 6NC	Eligibility Application

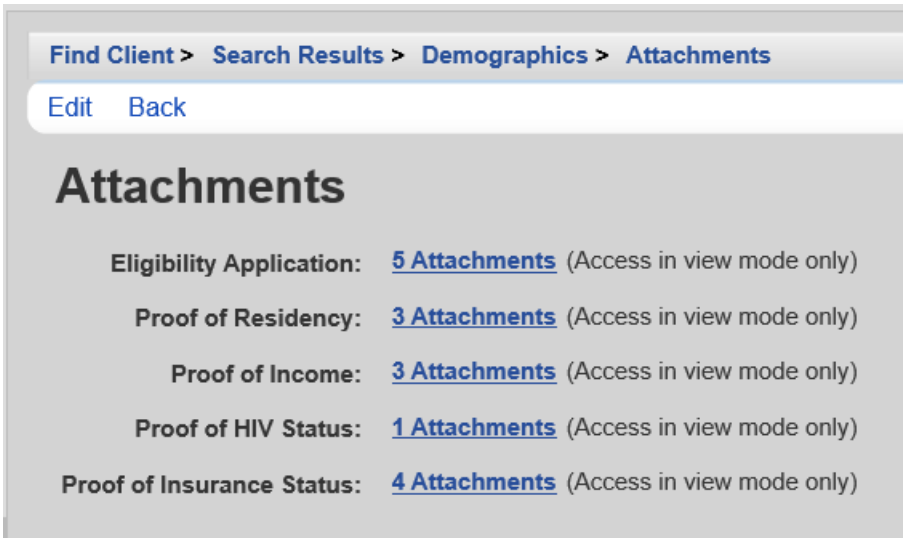
Uploading Documents:

- When in the client you are completing eligibility for, you will upload all eligibility documents into **Attachments**, which is on the demographics page.

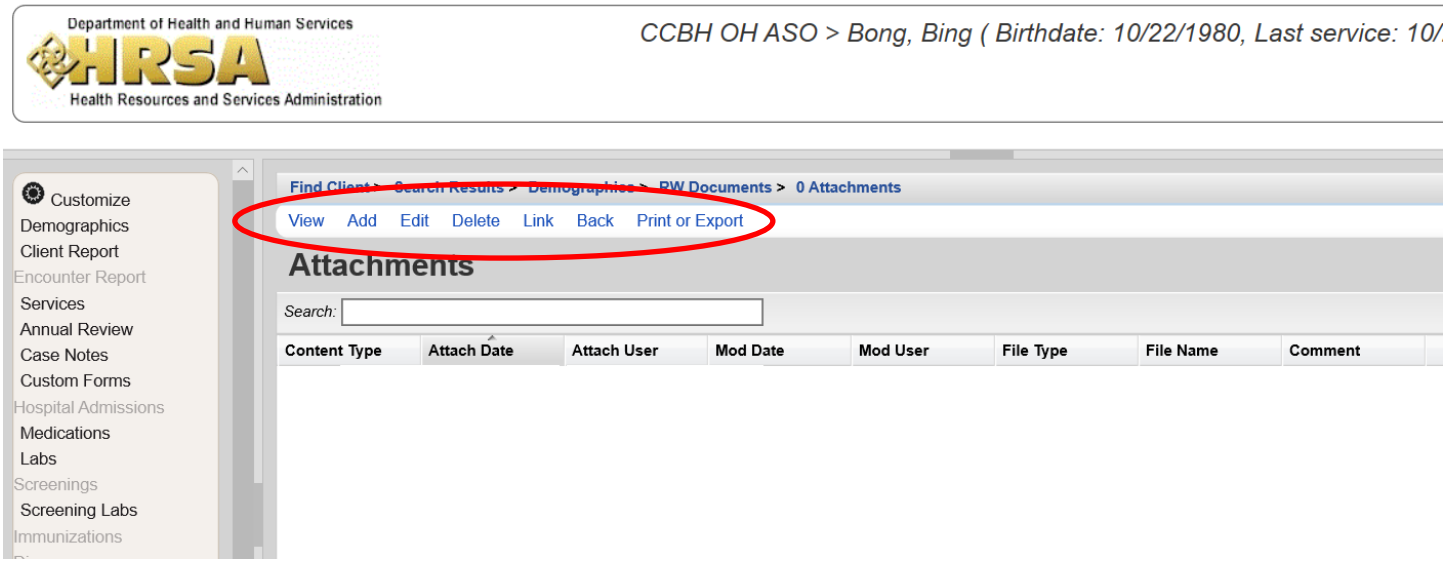


Clicking on "**Attachments**" will bring you to the following screen, from which you can upload eligibility documents: Eligibility Application, Proof of Residency, Proof of Income,

Proof of HIV Status, and Proof of Insurance Status such as the eligibility application and proof of residency.



By clicking on each blue hyperlink for which you need to upload documents, you will see the following screen, upon which you can View, Add, Edit, etc. each attachment:



APPENDIX F – DATA QUALITY

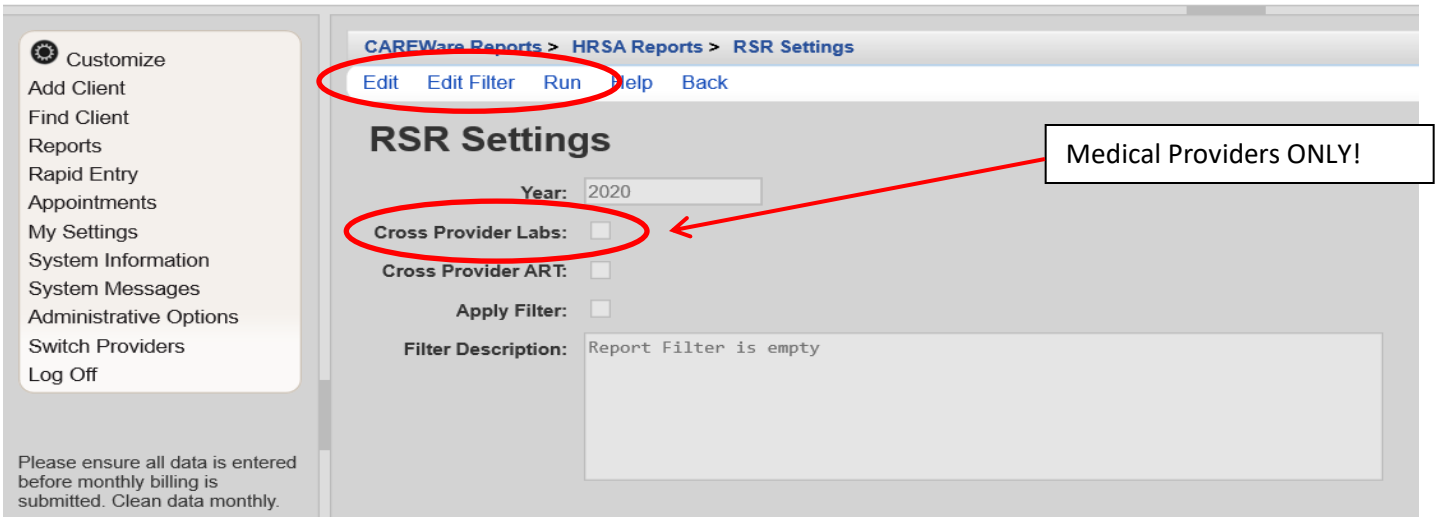
In CAREWare, enhanced RSR data quality reports are available, including the **RSR Client Report**.

To access this function, you will need to click on **Reports** in the far left navigation pane of the home screen (the screen you see after logging in i.e. cannot be done from an individual client's file). Then select **HRSA Reports**—within this link you will see the RSR Client Report, RSR Viewer, and RSR Validation Report.

To run an RSR, you will first select **HRSA Reports**, which will bring you to the following screen:

After selecting **RSR Client Report** you will arrive at the following screen from which you can edit the information, edit what filters you want to use, and finally, run the RSR Client Report. You will save this report to your desktop as YEAR_RSR_Export.xml (e.g. 2019_RSR_Export.xml)

NOTE: Medical Providers ONLY—check **Cross Provider Labs box.**



RSR Client Report – Steps Summary:

Running the RSR

1. From your home screen, select **Reports** from the far left navigation pane
2. From the **CAREWare Reports** screen, select **HRSA Reports**
3. From the **HRSA Reports** screen, select **RSR Client Report**
4. From the **RSR Settings** screen—after editing the desired settings—select *RUN* from the action bar
5. Once the report is complete, a notification will pop up in the top right of your browser, with a text box which says "Download RSR File"—click on that text to download the RSR file to your computer

6. Save the file on your computer (it is recommended to save the file to your desktop for easy access) as "YEAR_RSR_Export.xml" (e.g. 2019_RSR_Export.xml)

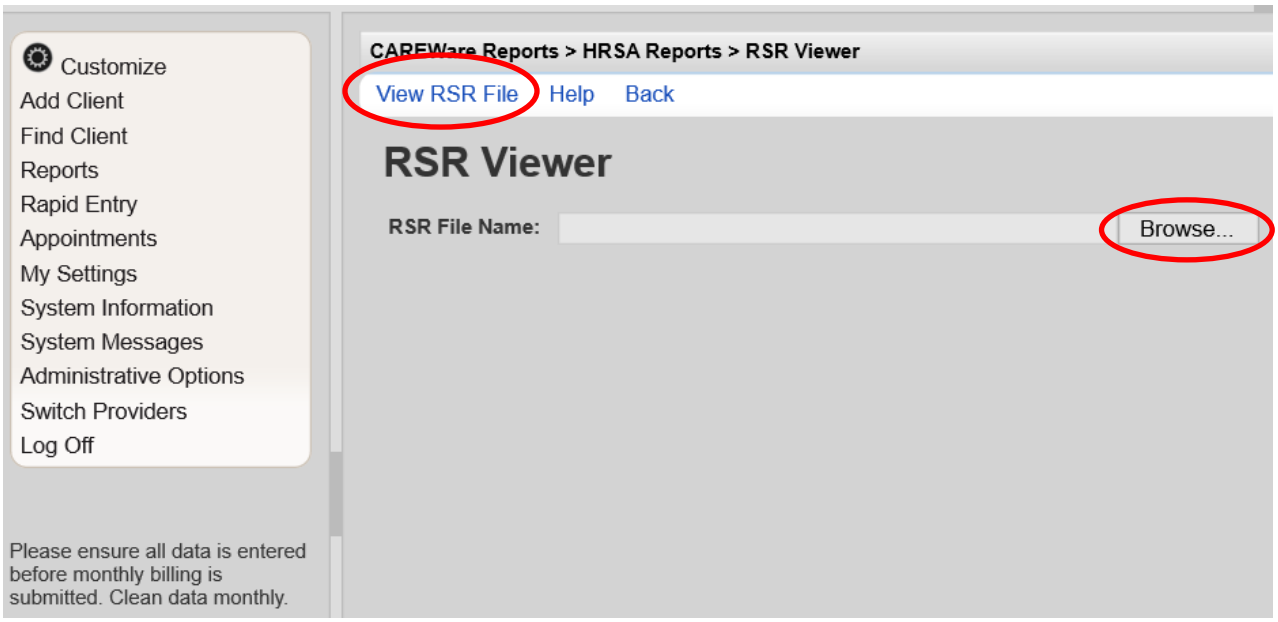
   Note: For easy viewing resize the columns.

Menus only allow for 20 rows of information/items *per page*. You may need to scroll down to see all the information on that page. Use the navigation buttons at the bottom to view additional pages of information/services/menu items if there is more than one page of results.

Viewing the RSR

1. From your home screen, select **Reports** from the far left navigation pane
2. From the **CAREWare Reports** screen, select **HRSA Reports**
3. From the **HRSA Reports** screen, select **RSR Viewer**

4. After selecting **RSR Viewer**, you will be bought to the following screen:

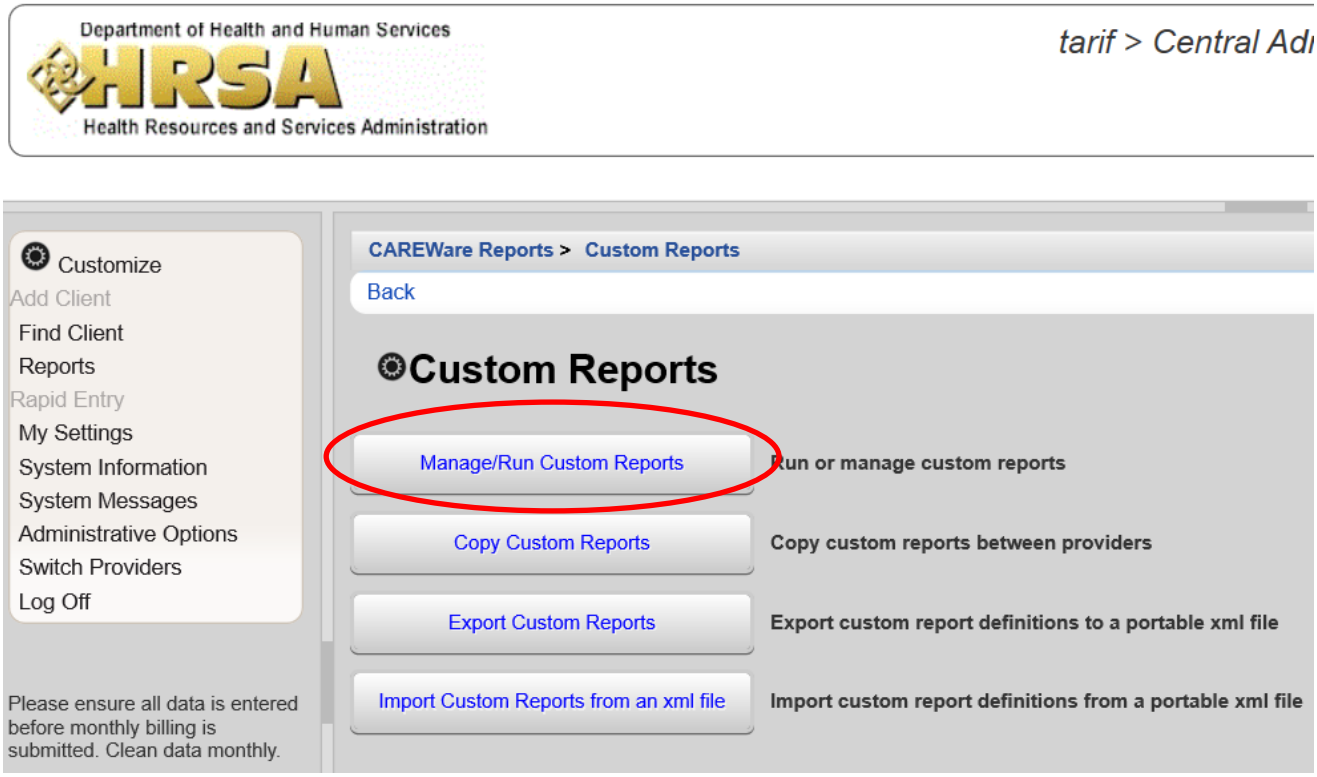


5. From the **RSR Viewer** screen, select **Browse or Choose File** and find the RSR XML file that you downloaded onto your desktop when running the RSR Client Report. Click on that file and select "Open" to view the RSR.

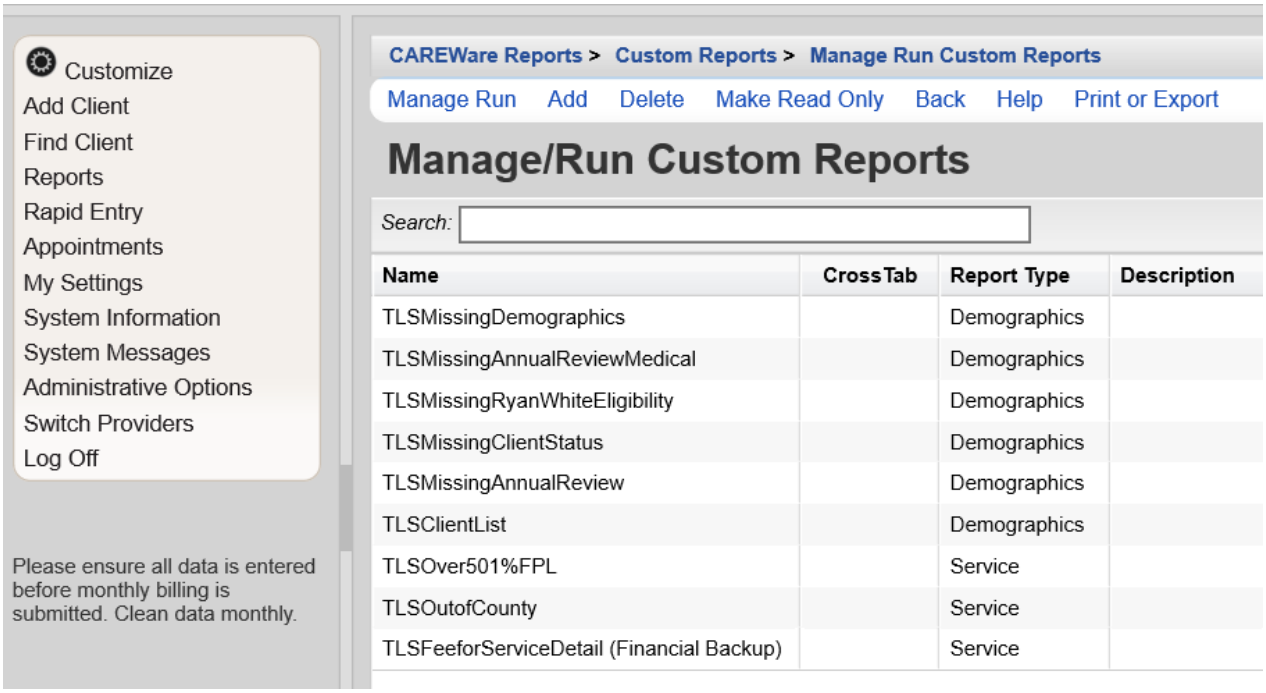
6. Select **View RSR File.**

Following are the five (5) data quality reports used to identify and correct missing client data in CAREWare at your agency. These reports should be run in the order listed, prior to submitting monthly reimbursement requests to the County. For each of the custom TLS missing data reports, set the Data Span from: 1/1/2020 through 12/31/2020 to display accurate results. To find these data quality reports, first navigate to the home screen of CAREWare 6 and select **Custom Reports**:

After selecting **Custom Reports**, you will see the following screen from which the required custom reports can be ran, copied, exported, or imported. To run the reports needed, select **Manage/Run Custom Reports**:



After selecting **Manage/Run Custom Reports**, you will be brought to a list of all custom reports available, shown below (note the search bar at the top of the list that can be used to quickly find a desired report):



1. **TLSMissingRyanWhiteEligibility**—clients listed have been reported as, 1) Not Eligible for Ryan White; however, 2) have received a Ryan White funded service in the reporting year. (Note: clients listed on this report will not be included on the annual RSR report, until corrections are made. As a result, your agency will not get full credit for client services or medical tests and screenings provided.)

   TO RESOLVE: This information can be updated in the Demographics section add an Eligibility History record for each qualifying Ryan White Funding Source(s); AND/OR delete/change the client service(s) to a non-Ryan White funded contract.

2. **TLSMissingAnnualReview** All sub-recipients must use this report. Clients listed may be missing insurance, income, or housing arrangement.

   TO RESOLVE: This information can be updated in the Annual Review section.

3. **TLSMissingAnnualReviewMedical** – Note: This is only for OAHS funded sub-recipients. Clients listed may be missing CD4, Viral load, Syphilis, ARV, and Pregnancy.

   TO RESOLVE: Add any missing information to the client file via the Clinical section.

4. **TLSMissingClientStatus -** Clients listed may be missing enrollment date, case closed date if discharged, vital status, HIV status, HIV risk, and/or HIV+ date, or AIDS date.

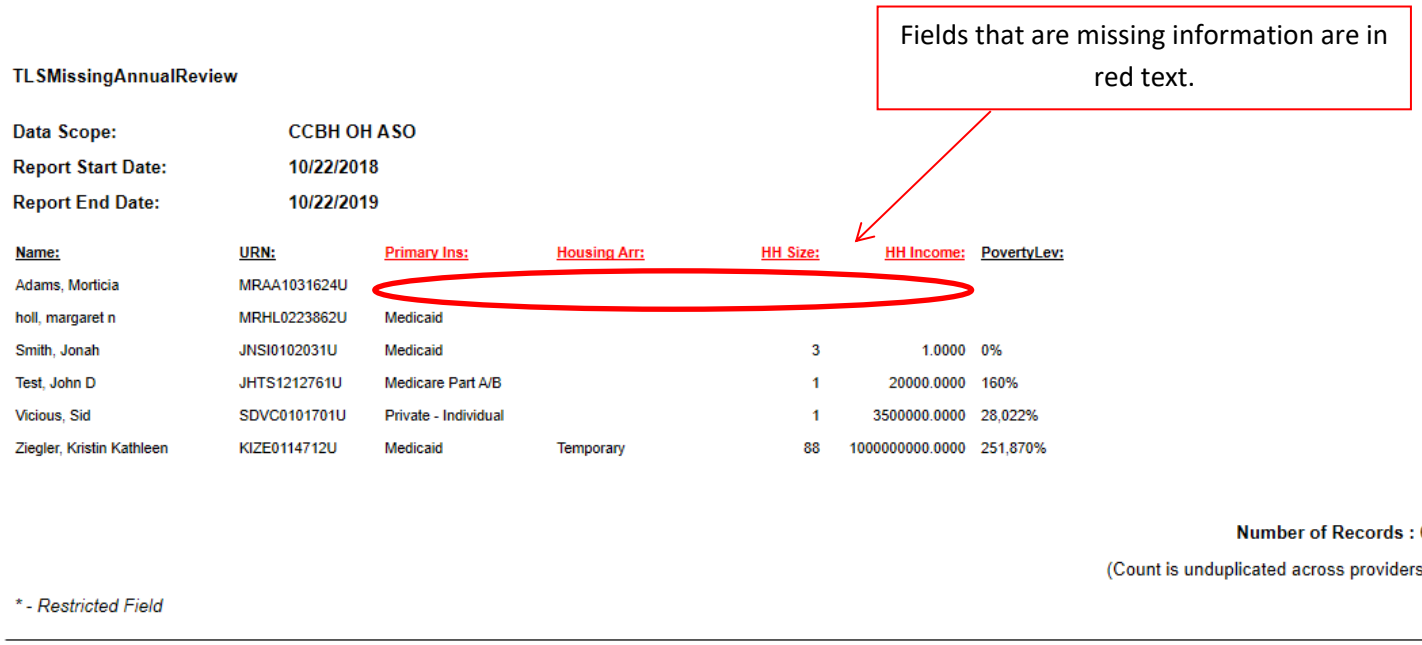
   TO RESOLVE: Add any missing information to the client file.

5. **TLSMissingDemographics** – clients listed may be missing ethnicity, race, street address, city, county, state, or zip code.
   TO RESOLVE: Add any missing information to the client file.

6. **TLSOutofCounty** - Clients listed have reported Ryan White funded services, however; are ineligible to receive Ryan White services, due to residing outside a county within the Transitional Grant Area (TGA). Agency reimbursement for client services allocated to Ryan White funding is disallowed.
   TO RESOLVE: Delete all Ryan White funded services or reassign to non-RW funded contracts for all clients listed.

7. **TLSOver501%FPL** - Clients listed have reported Ryan White funded services, however; are ineligible to receive Ryan White services, due to annual household income over 501% of Federal Poverty Level (FPL). Agency reimbursement for client services allocated to Ryan White funding is disallowed.
   TO RESOLVE: Delete all Ryan White funded services or reassign to non-RW funded contracts for all clients listed.

Upon double-clicking/opening any of the TLS, you will see the clients listed that have missing data. If a client is missing data, the field will be blank on the report. For example (for the purposes of the manual, we will be using sample client records—no actual patients' information is displayed here):



Fields that are missing information are in red text.

TLSMissingAnnualReview

Data Scope: CCBH OH ASO
Report Start Date: 10/22/2018
Report End Date: 10/22/2019

Name:	URN:	Primary Ins:	Housing Arr:	HH Size:	HH Income:	PovertyLev:
Adams, Morticia	MRAA1031624U					
holl, margaret n	MRHL0223862U	Medicaid				
Smith, Jonah	JNSI0102031U	Medicaid		3	1.0000	0%
Test, John D	JHTS1212761U	Medicare Part A/B		1	20000.0000	160%
Vicious, Sid	SDVC0101701U	Private - Individual		1	3500000.0000	28,022%
Ziegler, Kristin Kathleen	KIZE0114712U	Medicaid	Temporary	88	1000000000.0000	251,870%

Number of Records : 6

(Count is unduplicated across providers)

** - Restricted Field*

Use the TLS reports to identify which patients are missing information, as well as the type of missing information (i.e. housing, HH size, etc.) In this example we are using TLSMissingAnnualReview and sample clients. Any field that is missing information is in red text. For instance, for "Adams", the primary insurance, housing arrangement, household size, and household income.

Note: All missing data reports should be complete upon submitting your monthly invoices.

RSR TIP SHEET

2019 RSR Submission / HRSA Electronic Handbook
Using CAREWare to Create the Client Level Data XML Upload File

1. For complete step-by-step RSR data submission instructions, please refer to the HRSA/HAB 2019 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual, available for download here:

https://targethiv.org/sites/default/files/file-upload/resources/2019_RSR_Manual_091919_508.pdf

2. ***STEP ONE: Open the Provider Report*.** A valid registered user account on the HRSA Electronic Handbook (EHB) or HAB RSR Web Application system is required to submit your 2019 RSR Report to HRSA/HAB.

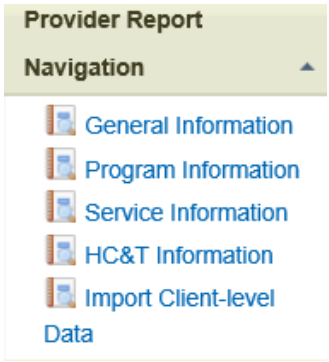
Recipient and Recipient-Providers:HRSA EHB **https://grants.hrsa.gov/webexternal >**Performance Reports.

Subrecipient Providers: HAB RSR
https://performance.hrsa.gov/hab/RegLoginApp/Admin/Login.aspx

Enter your username and password, and click "login." You will automatically be taken to the first page of your Provider Report. If you have submitted the RSR report in the past, you do not need to re-register in the system.

If you do not have an account, you will need to complete a **Registration Form**, which requires your agency's HAB Registration Code and Tax ID (EIN) number to create a username and password.

3. Log into your EHB or RSR user account and navigate to the Provider Report for your agency. You should see your agency name or organization, and a menu of options on the left pane, (similar to that listed below):



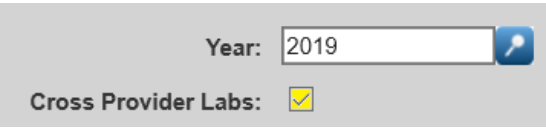
4. ***STEP TWO: Complete the Provider Report.*** Provider Report Navigation which has five links: **General Information**, **Program Information (1-4), Opioid-Use Treatment (5-7), Service Information (8)**, and **HC&T Information (9-15)**, as applicable. Click *Save* at the bottom of each web page and proceed to the next section.

(Opioid-Use Treatment - applies ONLY to medical providers.)

(HC&T Information - applies ONLY to agencies that are required to report anonymous HIV testing.)

5. ***STEP THREE: Complete the Client-Level Data Report.*** Import client-level data XML upload file from CAREWare. *Main Menu* > CAREWare *Reports* > *HRSA Reports* > *RSR* > ***RSR Client Report***

Medical Providers (ONLY): check the ***Cross Provider Labs:*** box, then *Run* the '**RSR Client Report**' to create the RSR client level data XML file.



*(It is recommended to add the reporting year to the file name and Save As - **2019_RSR_Export.xml** file on your computer's Desktop, for easy retrieval.)*

6. ***STEP FOUR: Validate your RSR Provider Report and client-level data.*** Validation of the 'RSR Provider Report' requires review of all report validation results. This may require fixing data errors in CAREWare and re-uploading a corrected client-level data file to the HRSA EHB or HAB RSR System.

- **Errors** – information that triggered the error **MUST be corrected** prior to submission; it may be related to contracts, services, missing or unknown client-level data, etc.;
- *Warnings* – should be corrected if possible or a comment must be entered explaining the data. (see the Ryan White Part A '*Warning Comments*' list for suggested provider comment(s);
- Alerts – are informative and intended to help you identify potential issues in your data collection and reporting processes. You can submit your report with alerts.

(Note: In subsequent RSR reporting periods - Alerts may become *Warnings*, *Warnings* may become **Errors**.)

7. ***STEP FIVE: Submit your data.*** Your 2019 RSR Provider Report includes agency information entered in the RSR Provider Report AND client-level data uploaded in the RSR Client Level Data Report from CAREWare.

Click **Submit** from the left Navigation panel menu options.

IMPORTANT: Continue to monitor the HRSA EHB or HAB RSR Web System and e-mails for changes in your 2019 RSR Provider Report status - through the submission deadline of **Monday, March 30, 2020 6:00 PM ET**.

IMPORTANT – The RSR system opens on Monday, February 3rd. All 2019 RSR Sub-recipient Reports need to be in "Review" status on the HAB RSR Web Application System by
Monday, February 17, 2020!

APPENDIX H – CLIENT-LEVEL DATA ELEMENTS – CLE MODIFIED

Need Help with the HRSA EHB or HAB RSR Web Application system?

Please contact the HRSA Contact Center at (877) 464-4772, available Mon - Fri, 8am - 8pm ET or electronically: http://www.hrsa.gov/about/contact/ehbhelp.aspx

Need Help with the HAB RSR data content and/or reporting requirements?

Please contact HRSA Data Support at (888) 640-9356 or email: RyanWhiteDataSupport@wrma.com

Have Program, Fiscal, or Agency Specific Questions? Please contact the Ryan White Part A program office -

Cuyahoga County Board of Health at (216) 201-2001 or reference http://www.ccbh.net/ryan-white

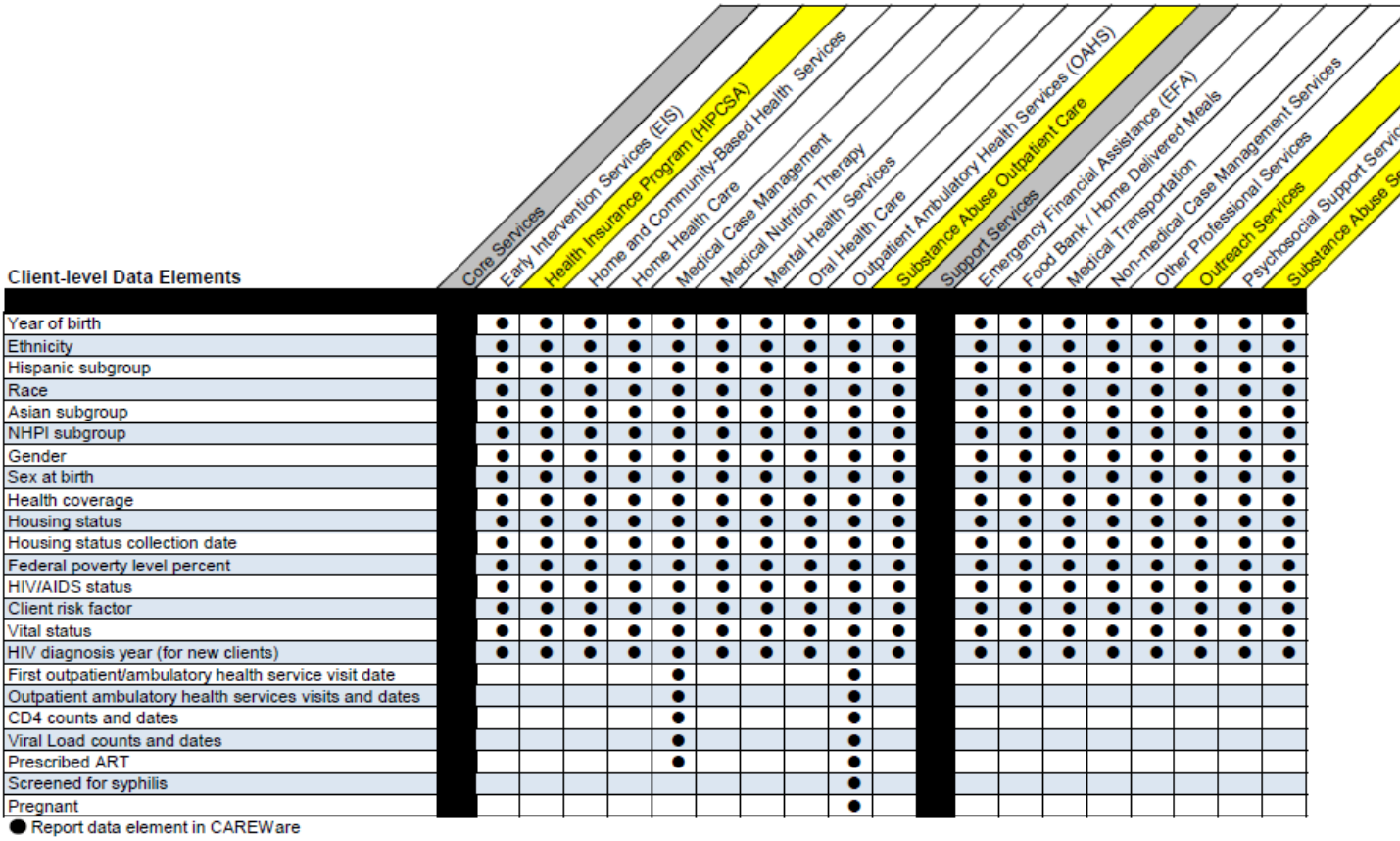
Need Help with CAREWare?

To arrange CAREWare technical support or training - please contact the Ryan White Program Office (CCBH) -

at (216) 201-2001 or e-mail Melissa Rodrigo, Ryan White Part A Supervisor, mrodrigo@ccbh.net

NOTE: Highlighted service categories are those that will not be funded for FY2020: Health Insurance Program (HIPCSA), Substance Abuse Outpatient Care, Outreach Services, and Substance Abuse Services (residential)

2020 RSR Reporting Requirements



Client-level Data Elements	Core Services	Early Intervention Services (EIS)	Health Insurance Program (HIPCSA)	Home and Community-Based Health Services	Home Health Care	Medical Case Management	Medical Nutrition Therapy	Mental Health Services	Oral Health Care	Outpatient Ambulatory Health Services (OAHS)	Substance Abuse Outpatient Care	Support Services	Emergency Financial Assistance (EFA)	Food Bank / Home Delivered Meals	Medical Transportation	Non-medical Case Management Services	Other Professional Services	Outreach Services	Psychosocial Support Services	Substance Abuse Services
Year of birth	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Ethnicity	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Hispanic subgroup	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Race	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Asian subgroup	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
NHPI subgroup	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Gender	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Sex at birth	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Health coverage	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Housing status	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Housing status collection date	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Federal poverty level percent	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
HIV/AIDS status	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Client risk factor	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
Vital status	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
HIV diagnosis year (for new clients)	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●
First outpatient/ambulatory health service visit date					●				●											
Outpatient ambulatory health services visits and dates					●				●											
CD4 counts and dates					●				●											
Viral Load counts and dates					●				●											
Prescribed ART					●				●											
Screened for syphilis									●											
Pregnant									●											

● Report data element in CAREWare

APPENDIX I – BILLING INSTRUCTIONS

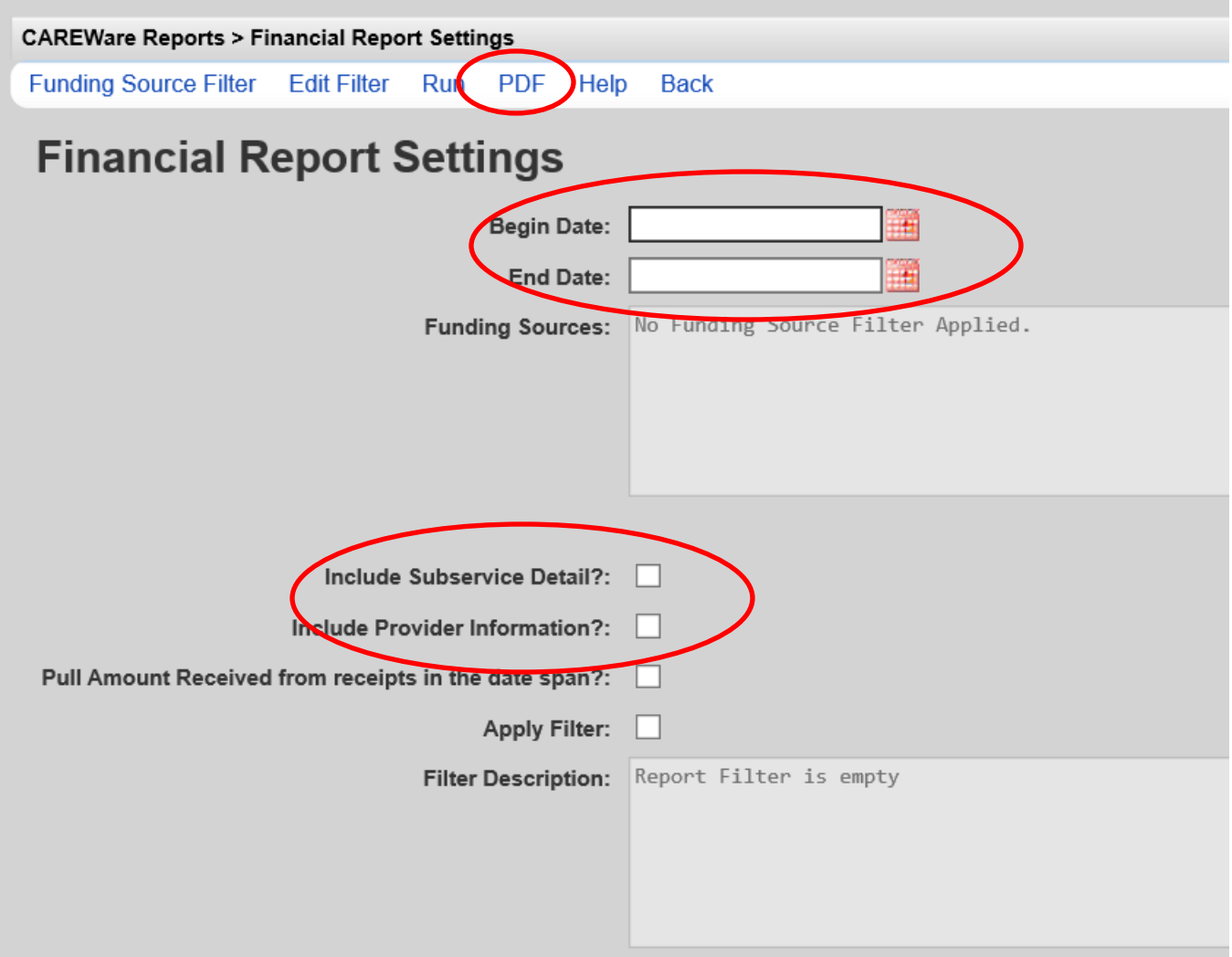
1. All service level data should be entered into CAREWare by your agency's agreed upon internal deadline. We suggest entering in data as close to real time as possible. Your agency should use the FY2020 CAREWare Activity Description spreadsheet to assure that you are using the proper unit descriptions and associated costs. Invoices will not be paid if services data is not entered into CAREWare.

2. As soon as all service level data is entered you will need to run the following two reports out of CAREWare:

a) From your home screen you will click the **Reports** tab on the far left navigation pane which will bring you to the following screen.

b) The first report you will run is the **Financial Report**:

Note: CAREWare 6 can only print Financial Reports if Google Chrome is being used.

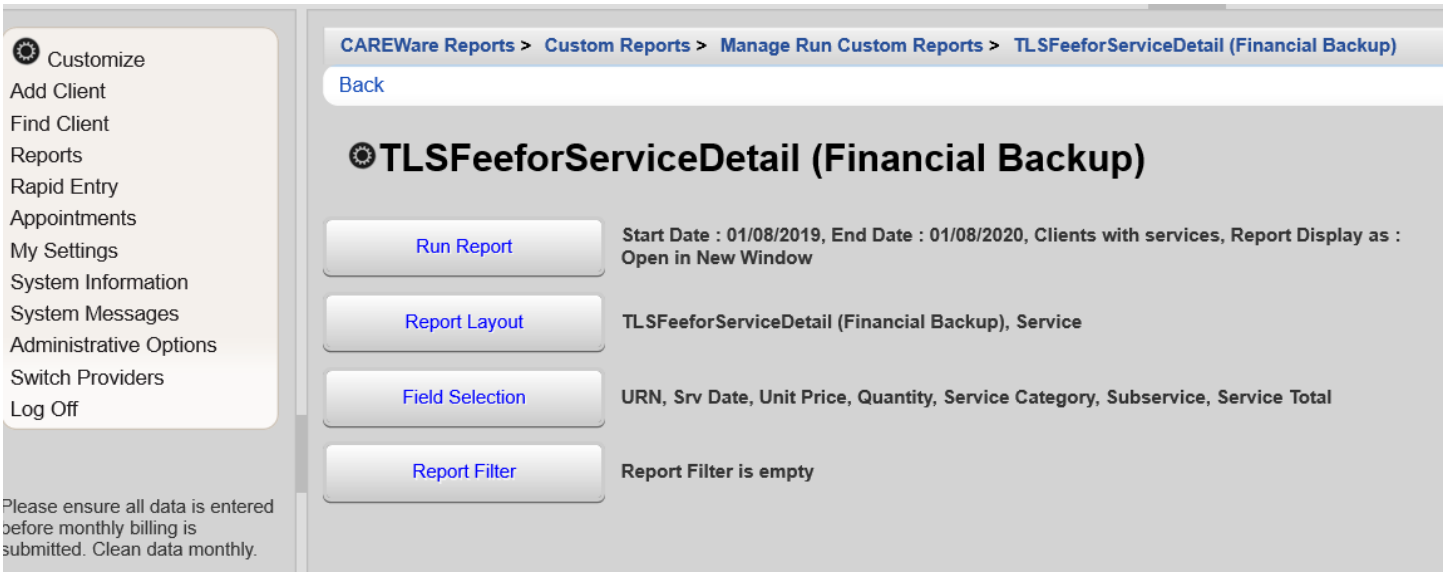


c) When setting up the Financial Report, make sure that you set the date range to the billing month and check the two boxes that say: *Include Subservice Detail* and *Include Provider Information*. Then you run the report.

d) Once you have reviewed and approved the Financial Report you will need to export it by clicking **PDF**—a black text box will pop up on the top right of the screen. Click "View Financial Report" to open the PDF and save this PDF to your computer.

e) The second report you will run is located under the custom reports tab: **TLSFeeForService.** Navigate to this custom report by first going to **Reports** on the left navigation pane, then to **Custom Reports**, then to **Manage/Run Custom Reports** which will bring you to all the custom reports that can be run. Double-click the listed report labeled **TLSFeeForServiceDetail (Financial Backup)** and run the report**.**

(Home page left navigation pane – "Reports" → Custom Reports → Manage/Run Custom Reports → TLSFeeForServiceDetail (Financial Backup) → Run Report



*Please note that some agencies have the ability to run this report with client names. Please make sure that you are not running the report with names for your invoice submission.

g) Click on "Run Report"—this report will open in a separate tab on your browser. To print out the report, you will need to right-click on the report. A "print" option should show up on the right-click.

3. Both of these reports should be printed from your computer and, depending on your agencies internal process, submitted to your fiscal contact or combined with the required items listed on the FY2020 Fiscal Checklist.

4. If your agency receives funding for Lab services under OAHS, or Emergency Financial Assistance (EFA):

- You will also need to maintain a monthly spreadsheet that includes the following information:
    - **Service Category Name**
    - **Client URN (CAREWare ID)**
    - **Date of Service**

- **Name of drug or lab service performed.**

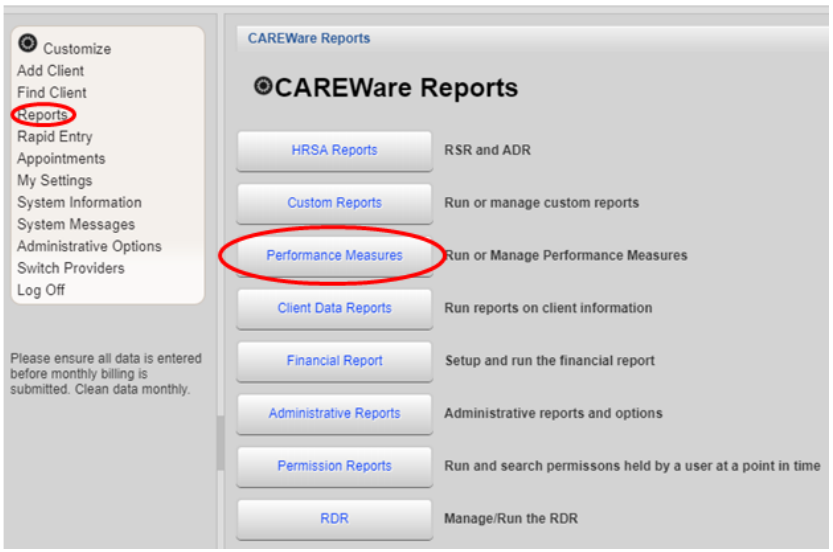
This spreadsheet should match the total number of units that you have entered into CAREWare and be submitted with your financial package on a monthly basis. Where applicable, a sample spreadsheet has been provided on your FY2020 flash drive.

- If you have services within these three categories that are not able to be billed during the current invoice period, you will also need to maintain a spreadsheet outlining back-charges within the grant period. This spreadsheet should also include:
  - Service Category Name
  - Client URN (CAREWare ID)
  - Date of Service
  - Name of drug or lab service performed.

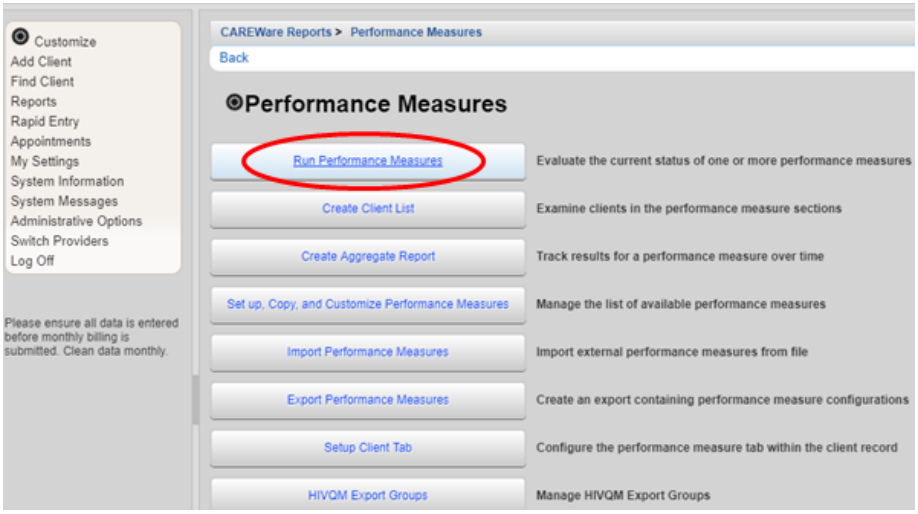
Again, where applicable, a sample spreadsheet has been provided on your FY2020 flash drive.

APPENDIX J – PERFORMANCE MEASURES

After logging in to your CAREWare account, click on **Reports** from the far left navigation pane. Under "CAREWare Reports", select **Performance Measures**.



Clicking Performance Measures will bring you to the following screen:

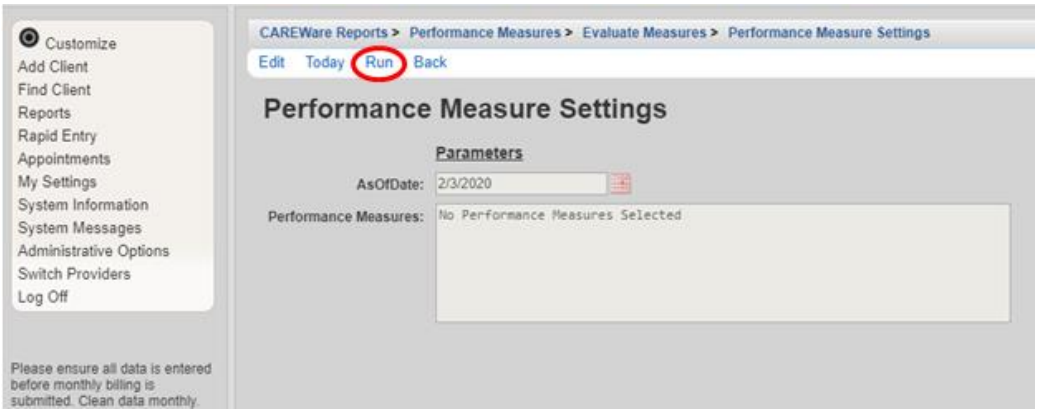


To evaluate a Performance Measure, select **Run Performance Measures**. This will bring you to a list of all the performance measures that can be run (example on next page).

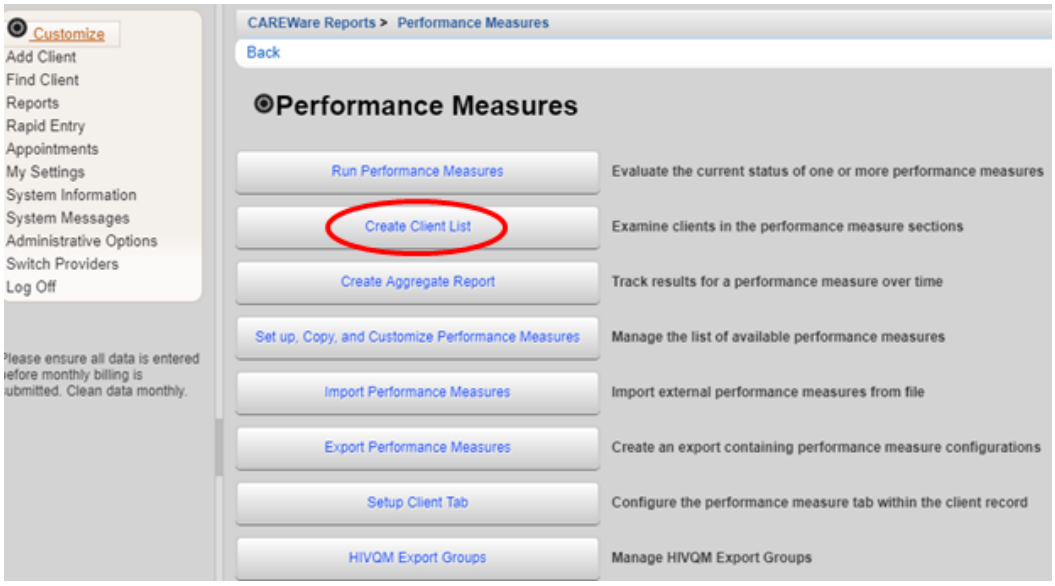
For CQM data pulls:
-Medical providers will use the reports with a code of VLMED, VLMEDYTH, VLMEDTRG, VLMEDMSM, VLMEDALW
-Non-medical providers will use the reports with a code of VLSUP, VLSUPYTH, VLSUPTRG, VLSUPMSM, VLSUPALW

Select the desired Performance Measures and click **Evaluate Selected**.

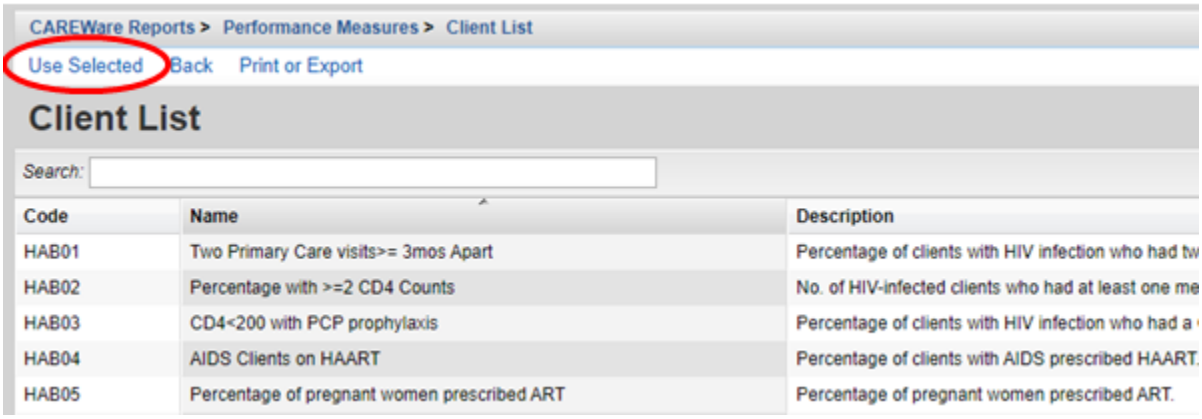
Edit the AsOfDate as needed and select **Run** to generate the Performance Measure report. The report will open in a separate tab on your browser.
Your report will pull a timeframe of one calendar year behind your AsOfDate (Ex: As of date 2-3-2020 = Timeframe of 2-4-2019 – 2-3-2020)



To **Create Client List** of a Performance Measure, select that option on the Performance Measures screen.

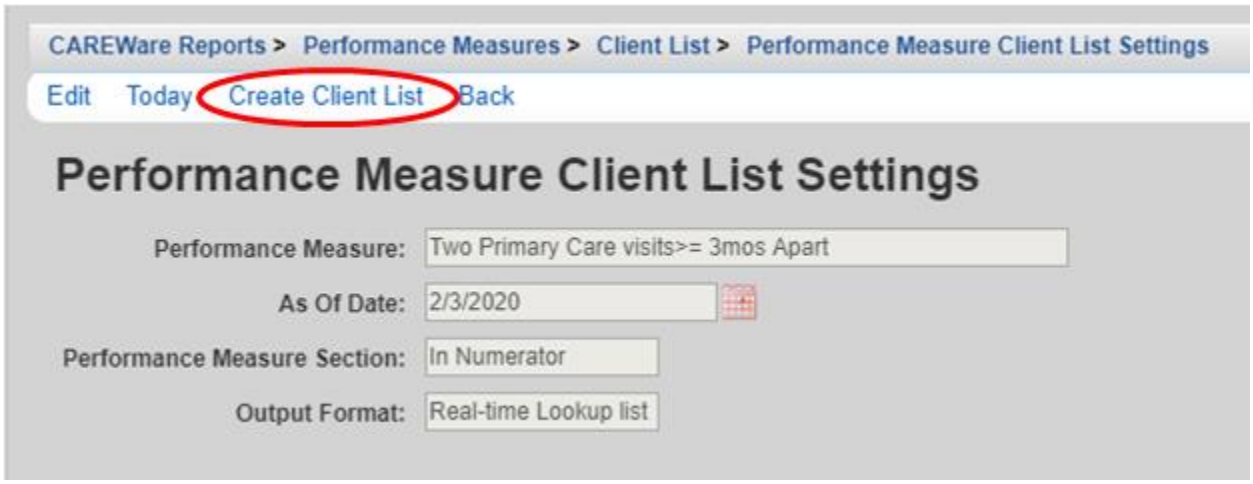


Select desired Performance Measures for the client list then click **Use Selected**:



Edit the information as desired and select **Create Client List**.

You can click "Edit" on the screen above to change client list settings.
Performance Measure Section:
Select 'In Numerator' to see those clients that are virally suppressed
Select 'Not in Numerator' to see clients who are not virally suppressed
Output Format:
Select 'Real-time Lookup List' to pull list that allows you to click clients to pull up client record.
Select 'Quick Paper List' to pull a printable list of clients.

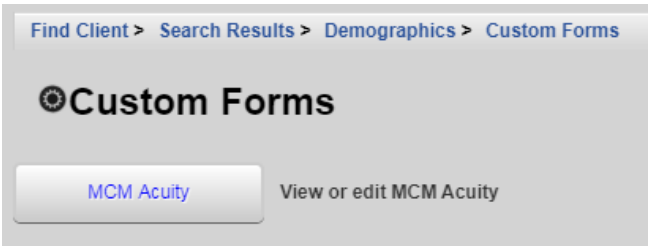


APPENDIX K – MCM ACUITY SCORE ENTRY

The Medical Case Management (MCM) Acuity Assessment must be completed once per measurement year for all MCM clients. This acuity score, along with the 6 month re-assessment score, will be recorded in CAREWare 6.

To add an annual acuity assessment score to CAREWare, you will first go into the client record and select **Custom Forms.**

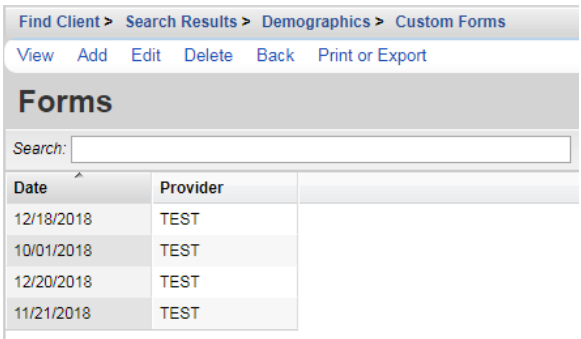
You will then be taken to the screen below, where you will click the hyperlink '**MCM Acuity.**'



The screen below will then be displayed. At this point you will be able to view all past MCM Acuity assessment scores.

If entering an annual assessment- click '**Add.**' (This will create a new form)

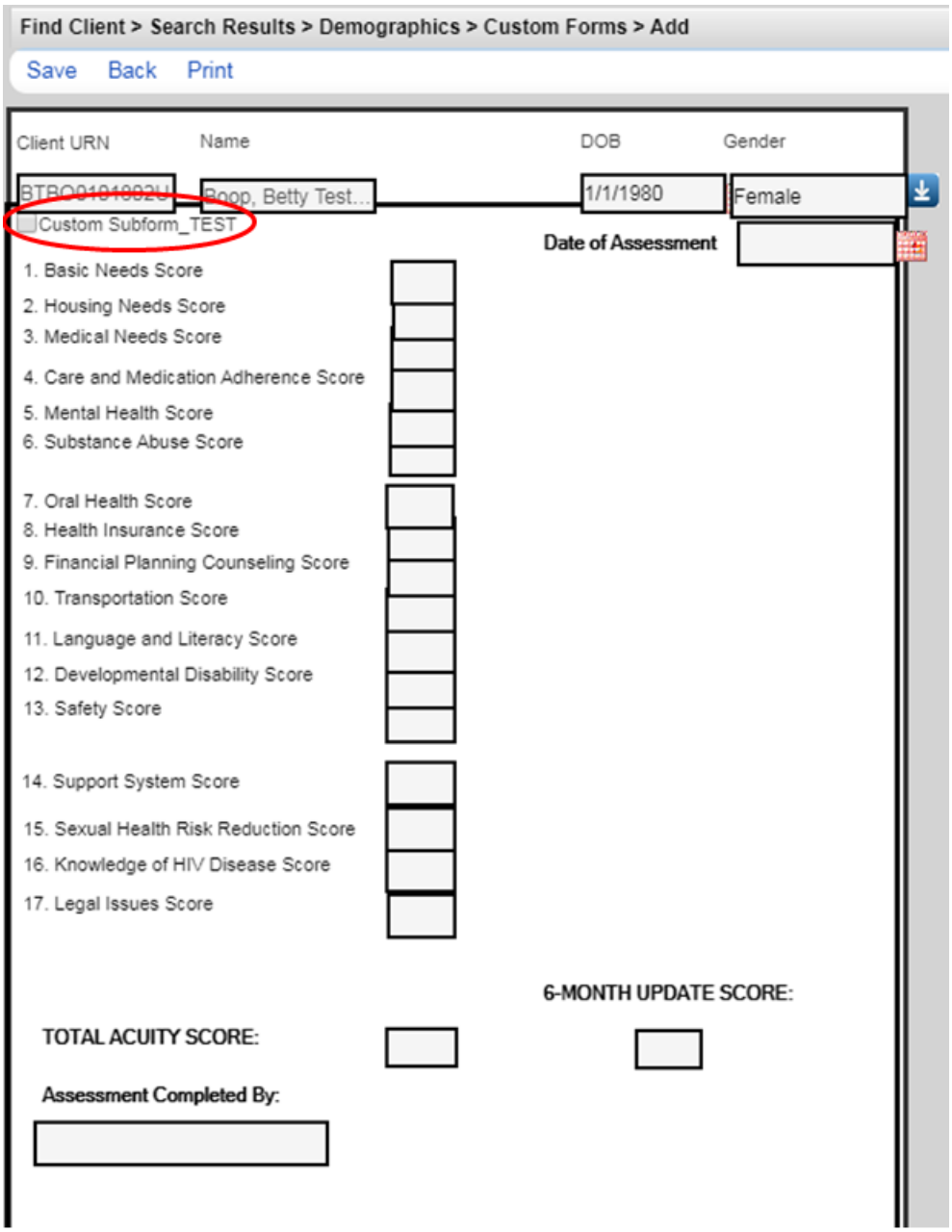
If entering a semi-annual assessment score – double-click on corresponding annual assessment date, which will take you to the assessment in which you can click '**Edit**' to add the total semi-annual acuity score and click '**Save**.'



If entering an annual assessment, you will be directed to the screen below.

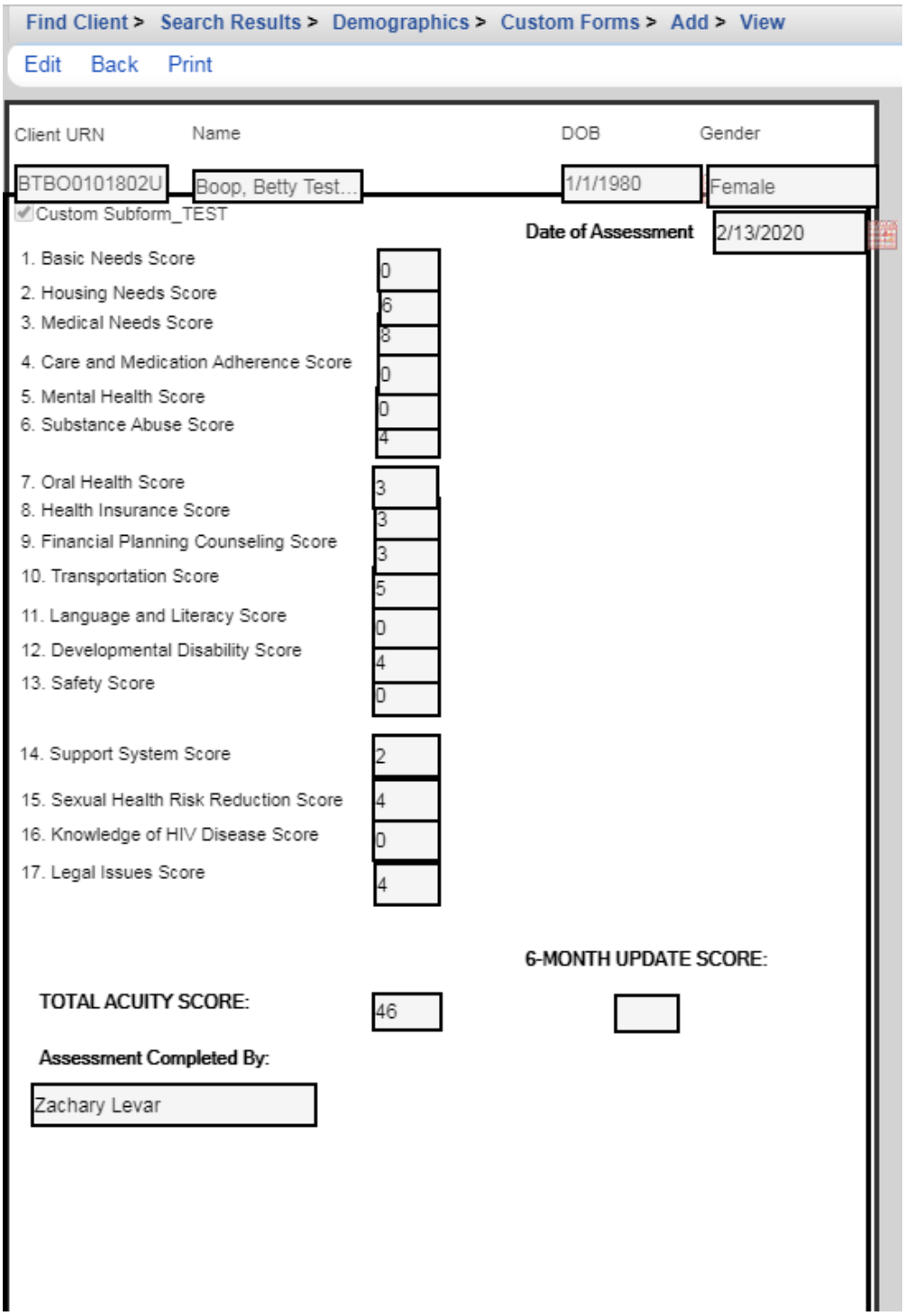
The Client URN, Name, DOB, and Gender will automatically populate. **To activate the form to complete the rest of the assessment, you must check the 'Custom Subform_TEST' box.** This will enable you to fill in the Date of Assessment, 17 acuity category scores, Total Acuity Score, and Assessment Completed By section.

All Part A Case Managers will have their names available in the "Assessment Completed By" section to choose their own name for each assessment they complete.



A fully completed annual assessment in CAREWare will look like the image below, you will then click '**Save**' to save the form.

*The Total Acuity Score will **not** automatically populate, you must fill this in manually*



APPENDIX L - RESOURCES

1) CAREWare Help Desk

Free technical support for the RW CAREWare software available to end-users nationwide.

Toll Free (877)294-3571
Mon - Fri
12pm - 5:00pm ET
Email: cwhelp@jprog.com

2) Using the CAREWare Modules

Link to interactive CAREWare on-line training modules, developed by the State of Oregon, (scroll to the bottom of the webpage, see 'CAREWare Modules'). This training consists of a series of 11 modules demonstrating the features of CAREWare.

http://public.health.oregon.gov/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/CaseManagerTraining.aspx

3) Join or Leave the NIH CAREWare ListServ

Sponsored by the National Institute of Health (NIH), CAREWare ListServ is an on-line user group forum. End-users can inquire and collaborate with colleagues regarding the use of modules and features in CAREWare.

https://list.nih.gov/cgi-bin/wa.exe?A0=CAREWARE

4) TARGET Center

Resource Library (archived HRSA/HAB webinars), News and Events, Ryan White Community, and Help Desk.

https://careacttarget.org/

5) Cleveland TGA Website

Resources for providers, and the community. Information includes local policy notices, presentations, training materials, service standards of care, and more.

www.ccbh.net/Ryan-White

Cuyahoga County Board of Health
Ryan White Part A Program
Cleveland TGA
2020
Clinical Quality Management Plan

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

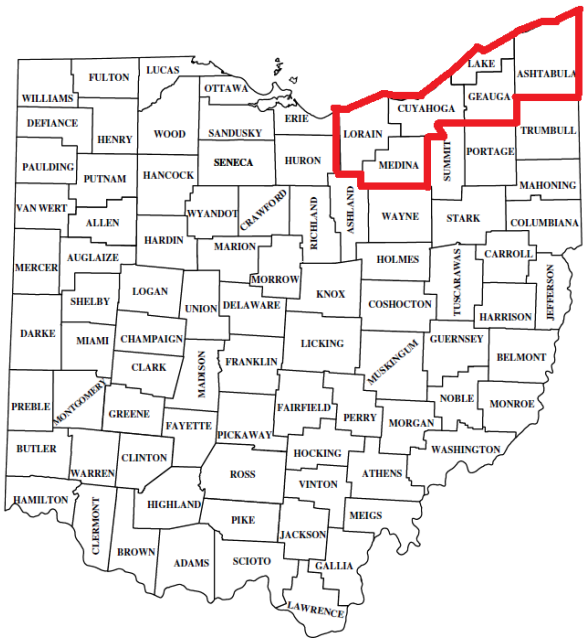
Updates approved by the Clinical Quality Management Committee on

November 18, 2019

Table of Contents

Introduction

Background: The Ryan White HIV/AIDS Program provides HIV-related services for those who do not have sufficient health care coverage or financial resources for HIV care and treatment. The program is federally funded through the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). In 1996, HRSA first designated the six county Cleveland region as a Ryan White Part A Transitional Grant Area (TGA).



The Cuyahoga County Board of Health (CCBH) (hereafter referred to as recipient) serves as the administrator of the Cleveland TGA grant which serves the following Ohio counties: Cuyahoga, Ashtabula, Geauga, Lake, Lorain, and Medina.

According to the Ohio Department of Health, in CY2018 there were a total of 5,857 individuals living with HIV/AIDS throughout the TGA region. The Cleveland TGA Part A Program provided care and support services to a total of 2,910 individuals in CY2018, or 50% of the region's total population living with HIV/AIDS.

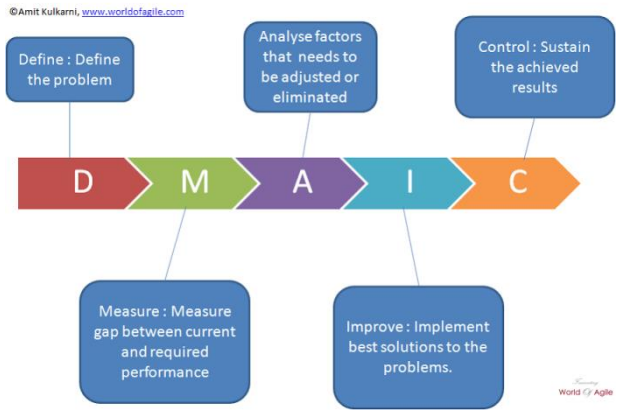
The TGA funds 13 sub-recipients to provide services that are designed to treat individuals living with HIV and provide support services to achieve optimal health outcomes, engage patients in ongoing HIV care, and work towards ending the AIDS epidemic. These services may be social service or clinical in nature, and all service categories have specific quality improvement targets.

Legislative Requirements: Ryan White Part A recipients are required to implement Clinical Quality Management activities. Specifically, the Ryan White Program legislation dictates that all recipients must: "establish a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections. [As applicable, recipients should] develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." In addition to legislative requirements, HRSA/HAB requires recipients to establish and implement a written Clinical Quality Management Plan to guide quality related activities in the local service area.

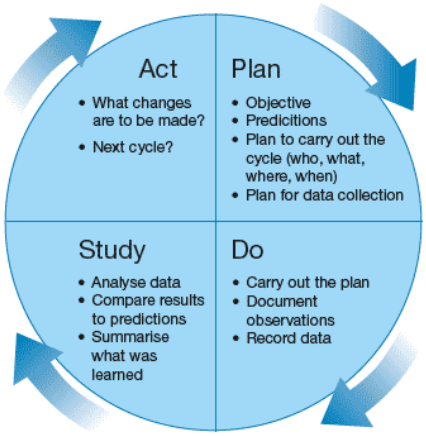
Quality Terminology

The following definitions are included in the HIV/AIDS Bureau Ryan White Part A Program Manual and used consistently throughout the Cleveland TGA Clinical Quality Management Plan:

- **Quality:** is defined by HAB as the degree to which a health or social service meets or exceeds established professional standards and user expectations. In order to continuously improve systems of care for individuals and populations, evaluation of the quality of care should consider:
  - The quality of inputs
  - The quality of the service delivery process, and
  - The quality of outcomes.
- **Clinical Quality Management (CQM)**: A formal system to routinely evaluate the quality of care and staff/patient experiences at RWHAP-funded organization, including an established infrastructure to manage improvement activities, routine measurement processes, capacity building efforts, and stakeholder involvement.
- **Clinical Quality Management Plan (CQMP)**: A written plan outlining the agency's quality management infrastructure (including clear responsibilities and accountability for activities) and process for ongoing evaluation and assessment to identify and improve the quality of care.
- **Quality Improvement (QI)**: An organizational approach to improving quality of care and services using a specified set of principles and methodologies, including, but not limited to, leadership commitment, staff involvement, cross-functional team approach, consumer orientation, routine performance measurement, and a continuing cycle of improvement activities.
- **DMAIC Process** A model for performance improvement
  - Define – Define the problem
  - Measure – Quantify the problem
  - Analyze – Identify the cause of the problem
  - Improve – Implement and verify the solution
  - Control – Maintain the solution



- **Plan Do Study Act (PDSA) Cycles:** A model for performance improvement:
    - PLAN - Identify and analyze what you intend to improve, looking for areas that hold opportunities for change.
    - DO - Carry out the change or test on a small scale (if possible).
    - STUDY - What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?
    - ACT - Adopt the change, abandon it, or initiate the cycle again.



- **Indicator:** A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or the level of quality achieved. Indicators serve as an interim step toward achieving a performance measure and are also referred to as activities.
- **Outcomes:** Results achieved for participants during or after their involvement with a service or program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, conditions or health status.
- **Outcome Indicator:** An outcome indicator is the specific information that tracks program success or failure towards meeting outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.
- **Quality Assurance (QA):** A formal set of activities to review and to safeguard the quality of services provided, QA includes quality assessment and implementation of corrective actions to address deficiencies. It is focused on identifying problems, ensuring that standards are adhered to and solving single quality issues with problem resolution focused on the responsible individual. QA is used more in a regulatory environment.
- **Standards of Care:** Performed and agreed upon principles and practices for the delivery of services that are accepted by recognized authorities. The standard of care is based on research (when available) and the collective opinion of experts.

For additional acronyms definitions, please see *Appendix E.*

Quality Statement

The overall mission of the Cleveland Transitional Grant Area Clinical Quality Management Program is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all HIV-infected individuals served by the TGA. Culturally and linguistically competent medical and social service provider's work collaboratively with administrative staff and consumers to create, implement, and maintain a dynamic program to facilitate receipt of comprehensive, state of the art, high quality care. This Clinical Quality Management Program aligns with the 2020 National HIV/AIDS Strategy goals, and adheres to established HIV clinical practice standards and Public Health Service guidelines in order to best address the needs of the Cleveland TGA community.

The vision of the TGA Clinical Quality Management Program is to improve and enhance the health and wellness of the population we serve. Through the work of the Clinical Quality Management Committee, the CQM Program aims to become a local resource for anyone wishing to improve the outcomes and support services of HIV health care for consumers, communities, and public health.

Quality Aims and Annual Quality Goals

The Clinical Quality Management Program works towards meeting or exceeding HAB expectations to establish and maintain a clinical quality management program and alignment with the National HIV/AIDS Strategy 2020 (NHAS). The Clinical Quality Management Program includes documented accountability for all service provision, with quantitative performance measurement and capacity building for providers and consumers resulting in ongoing and meaningful improvement activities.

Quality Aims

- Implement the Standards of Care for all funded service categories
- Improve CAREWare data entry: clean, current, comprehensive. The aim is to have CAREWare output more closely aligned with EMR data abstractions.
- Conduct and monitor ongoing quality improvement projects that promote patient linkage, retention, adherence, and viral suppression.

Quality Goals

Although the TGA assesses performance on numerous measures, the quality improvement focus will target Viral Suppression. Data that depicts progress towards goals are collected quarterly, trended, and shared back with all stakeholders.

Performance Measure	Reporting Provider	*National Benchmark	TGA Goal
Viral Suppression: Percentage of HIV patients with a viral load less than 200 copies/ml.	All funded medical and support service providers	85%	90%

* Ryan White Services Report, 2017

Clinical Quality Management Committee Infrastructure

The Clinical Quality Management Program operates through a Clinical Quality Management Committee (CQMC) which receives guidance and support from the TGA recipient office. Input is received from all providers, both clinical and social service, who are funded by the TGA, in addition to consumers and non-funded community partners. Priorities are established in concert with the Planning Council and aligned with local, regional, and national concerns.

The purpose of the CQMC is to establish a vehicle through which all providers can coordinate efforts to demonstrate improvements in the services they provide. Needs for capacity building is assessed and training opportunities are provided as appropriate. These efforts all contribute to an improved health status for Cleveland TGA patients. These activities will yield a higher rate of virally suppressed patients and ultimately, lower HIV transmission rates.

To assure that all aspects of patient health are included in the quality improvement effort, the CQMC is comprised of an array of members, representing all agencies funded by the TGA. The CQMC seeks to represent a variety of skill sets as well as a variety of provider disciplines. In addition to social service and clinical representation, the CQMC engages members who can manage data, provide secretarial and logistical support, assist with capacity building, and provide the consumer voice. The CQMC acknowledges that all voices are heard and respected.

Key Roles and Responsibilities:

The ultimate responsibility for quality management activities lies with the TGA Project Director. This person provides encouragement and support for improvement work by assuring that the committee has the resources they need to function effectively. The primary resource is sufficient staff time to allow for full participation. Although the Project Director may not be involved in the daily work of quality management, her support will help establish a culture of quality throughout the TGA.

Direct responsibility for the operation of the CQMC will rest with the TGA Program Supervisor. The Program Supervisor is the direct liaison to the HRSA/HAB Project Officer and shares HRSA/HAB priorities with the CQMC membership. The Program Supervisor coordinates sub-recipient contracts and assures the commitment to quality improvement is clear. The Supervisor ensures resources are available for space as needed for meetings, conference lines, photocopying, and any technical audio or video equipment needed to promote communication or encourage learning and sharing. She oversees all CQMC meetings and the overall direction of the committee.

The Program Manager serves as the day to day Quality Leader for the TGA. He sets the overall quality improvement initiatives within the TGA. He assumes the responsibility for monitoring improvement projects conducted by each sub-recipient. In addition, he sets the agendas for the CQMC meetings. The Program Manager, accompanied by the TGA Grant Coordinator, makes an annual site visit to each sub-recipient to assess progress at a local level. He is responsible for completing data reports, including quarterly aggregation and trending data back to CQMC members as a feedback and progress report mechanism. The Program Manager works with TGA data resources to provide timely and informative data reporting. The Program Manager represents the Cleveland TGA on the State of Ohio's Response Team for the HIV Cross-part Care Continuum Collaborative (H4C). This opportunity to liaison between the TGA and statewide H4C Collaborative provides an added opportunity to learn from and share with HIV providers across the State.

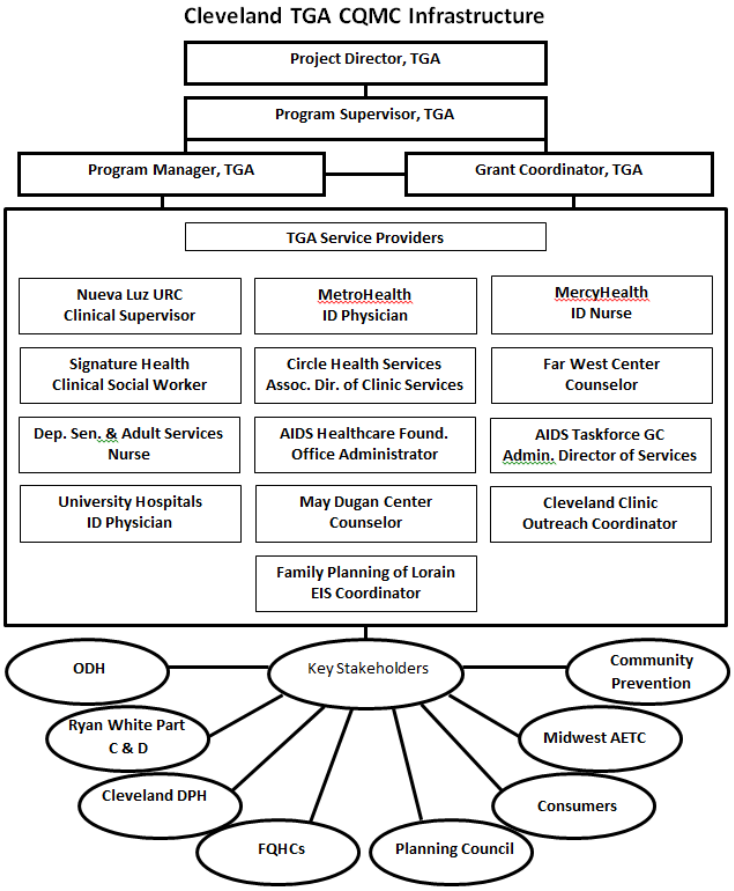
The necessary logistical and secretarial support responsibilities are conducted by the TGA Grant Coordinator. He secures space, takes and publishes meeting minutes, and provides any other facilitation needed by the committee members. The Grant Coordinator works cooperatively with the Program Manager to provide assistance and support for the routine operations of the CQMC. He also works with sub-recipients in their attempts to provide high quality services in alignment with the approved Standards of Care.

The CQMC recognizes the criticality of consumer participation and welcomes their experience and input. The consumers will describe patient barriers and challenges to care, and provide insight into quality improvement strategies and interventions. With the support of the TGA, consumers will have a basic understanding of HIV terminology and the quality improvement process, and will be willing to take part in additional training opportunities preparing them to contribute effectively.

Internal Key Stakeholders are the contracted sub-recipient service providers. These committee member's each liaison with their own agencies, and share quality improvement tools and trainings with their own quality management staff. The service providers are continually engaged in quality improvement projects, and are responsible to report progress at each quarterly meeting. Clinical sub-recipients share at least one common quality improvement project focusing on true health outcomes, but may engage in additional ones as appropriate. Non-clinical sub-recipients continue to work on an aspect of their funded service delivery that contributes to a positive impact on the patients' health outcomes. This includes helping the patient with linkage, re-engagement and retention in medical care.

The CQMC also engages external stakeholders who will make significant contributions to the successful operation of the committee. The Ohio Department of Health can share surveillance and epidemiology data, the AETC can assist with needs assessments and training programs, and other local experts can share information on mental health, substance abuse and dental concerns. The CQMC will coordinate ongoing improvement projects within the community. In order to enhance communication, the Planning Council Quality Committee has been identified as a key external stakeholder on the CQMC for the purposes of sharing information to ensure all quality projects and outcome are known throughout the community.

The organization of the CQMC can be depicted as such:



Capacity Building

The TGA recipient and the CQMC recognize the need for ongoing capacity building regarding quality improvement, for both the TGA leadership and staff as well as for the sub-recipient providers and CQMC members. It is noted that currently there is a wide range of QI skill level and competency among the providers and CQMC members. The large medical hospitals are already adept in identifying areas for improvement, strategizing to develop feasible

interventions, crafting Quality Improvement Projects (QIPs), and using data and measurement to demonstrate progress and success.

Although all levels of capacity building and training activities are planned, the immediate focus is on identifying the training needs of the Community-Based Organizations (CBOs). These providers may need more guidance and a different type of training. The CBOs are not clinical organizations, and do not collect viral load or other medical information. Therefore, they are unable to directly impact viral suppression or other major health outcome indicators. They are however, expected to contribute to the patient's linkage, re-engagement, and retention in medical care. These organizations provide the patients with basic living needs, such as food, shelter, and social service supports. As these needs are being met, the CBO staff encourages continued retention in medical care. Training on how this patient interaction should occur, how patient responses are documented, and how information is communicated between the recipient and the medical provider and the CBO, are all pathways to capacity building opportunities.

The CQMC works with the Program Manager and Grant Coordinator to research and explore the various training resources available. During the span of this CQM Plan, it is expected that the following resources help to shape and guide the capacity building efforts:

- QI 101 tutorials from the HRSA Ryan White HIV/AIDS Program Center for Quality Improvement & Innovation (CQII). The specific presentations selected would include basic topics such as why we do improvement work, the PDSA model, identifying areas for improvement, thinking through interventions, and documenting and measuring results.
- The AIDS Education and Training Centers (AETC). The CQMC will engage the expertise of the AETC staff, particularly in training nurses in HIV 101 topics. The AETC may also be asked for referrals regarding other expert speakers as needed when topics are identified.
- Internal experts. There exists a wealth of expertise within the TGA community. Quality Improvement leaders within the Ryan White funded hospitals may be asked to share their knowledge with the rest of the CQMC members and sub-recipient providers. Their "real world" experiences in the QI arena will help others better understand the QI process.
- External experts. Within the larger community there are local experts who are not funded by Ryan White, who may be able to share information regarding their own area of service. These areas might include such services as mental health or substance abuse, and these experts might be able to bring updates or new insights to our own providers.

It is possible that as the CQM Plan progresses, different topics are identified and the trainings focus on a different priority than initially decided. However, the regularity of trainings should not significantly change.

It is also possible that additional, but smaller and more local trainings may be required to address the needs of smaller groups of providers, or the needs of a single agency. These efforts are coordinated by the Quality Program Manager and the Grant Coordinator as they conduct sub-recipient site visits and identify new QI challenges.

In March and April of 2018, as well as May of 2019, capacity building took place through CQII'S TCQ Program. The Training for Consumers on Quality Program (TCQ) Program seeks to build consumer capacity for clinical quality management activities and to make consumers contributing members of recipients' clinical or non-clinical quality management program. The TCQPlus is a Training-of-Trainers program for the TCQ. Participants register in pairs: a consumer and a staff member from a RWHAP recipient. This built training capacity for local quality improvement training for consumers, conducted *by* consumers. The Cleveland TGA had two consumers from our CQMC committee attend the training.

Performance Measurement

Performance measurement is an integral part of the quality improvement process. Ongoing measurement of core indicators helps to determine and drive the Quality Improvement Projects (QIP). Once a QIP is identified and implemented, repeated measurement of performance helps determine the success or lack of success of a new or ongoing intervention.

There are two main sources of data on which the CQMC can rely for information regarding performance, the first of which is CAREWare. All of the sub-recipients utilize CAREWare, which houses all of the Ryan White Services Report (RSR) requirements. CAREWare queries are run multiple times a year to inform the CQMC on the TGA's key QIPs. The key QIP measure will be viral suppression, which is briefly outlined in the "Annual Quality Goals, Outcomes and Aims" section. Data from CAREWare can be collected from each sub-recipient,

aggregated for a TGA total picture, and trended out over time. Each sub-recipient will be able to visualize how their own work is contributing to the larger TGA picture.

Data reports are constructed according to the following time table:

Report	Due Date	Measurement Year
1	January 2020	January 1, 2019 through December 31, 2019
2	April 2020	April 1, 2019 through March 31, 2020
3	July 2020	July 1, 2019 through June 30, 2020
4	October 2020	October 1, 2019 through September 30, 2020
5	January 2021	January 1, 2020 through December 31, 2020
6	April 2021	April 1, 2020 through March 31, 2021
7	July 2021	July 1, 2020 through June 30, 2021
8	October 2021	October 1, 2020 through September 30, 2021

Recipient staff has access to the medical records and charts at each sub-recipient agency. Thus, additional measures are able to be evaluated during a routinely scheduled annual site visit. Data from charts and EMRs are abstracted on a random sample population. HAB guidance is used to determine the number of records needed to demonstrate confident data. These data are also able to be aggregated, trended out over time by year, and returned to the CQMC for discussion and evaluation.

The following indicators are routinely measured annually via chart abstraction. This activity affords the CQMC an opportunity to review results on the 3 key measures and QIPs from two data sources: CAREWare and chart abstraction. Ideally the two sets of data tell the same story. Recipient staff work with sub-recipients to keep all data, both electronic and charted, as current and as comprehensive as possible. Should the focus of a QIP shift to a measure outside of those routinely evaluated, the CQMC may decide to abstract additional data to help inform that area of interest. These might include Pap screens, flu shots, HCV screens, dental care or numerous other key concerns for HIV patients.

Outpatient Ambulatory Health Services (OAHS): HAB Performance Measure	National Benchmark	Cleveland TGA Target Results
Viral Suppression: Percentage of patients with a HIV viral load less than 200 copies/ml.	**85%** (2017 Ryan White Services Report)	**90%**
Prescription of HIV Antiretroviral Therapy: Percentage of patients prescribed HIV antiretroviral therapy.	**91%** (2012 HIV Research Network)	**90%**

Medical Case Management: HAB Performance Measure	National Benchmark	Cleveland TGA Target Results
Medical Case Management Case Plan: Percentage of patients who had a medical case management care plan developed and/or updated two or more times in the measurement year.	No National Comparison Available	**80%**
Medical Case Management Linkage to Care: Percentage of MCM patients with at least one medical visit, viral load, or CD4 test within the measurement year	No National Comparison Available	**80%**
Medical Case Management Viral Suppression: Percentage of MCM patients with a HIV viral load less than 200 copies/ml.	No National Comparison Available	**80%**

For more information regarding the Cleveland TGA's 2017 and 2018 viral suppression results, reference **Appendix E**.

Quality Improvement Projects and Monitoring

The implementations of Quality Improvement Projects (QIPs) is the cornerstone of the CQMC work and responsibility. Ongoing measurement determines if a QIP is successful or if it needs modification. The key QIPs are determined at the onset of each new/revised CQM plan, but may be modified at any time during the duration of the CQM plan. Additional QIPs may be assigned at the sub-recipient level at any time during the CQM plan cycle as determined necessary by TGA recipient staff.

As described in the Quality Terminology Section above, the applied framework to implement QIPs in the past has been the Plan-Do-Study-Act (PDSA) cycle, developed by Walter A. Shewhart. This approach is part of the Model for Improvement, developed by Associates in Process Improvement, which helps teams accelerate the pace of change. This year, the agencies are utilizing a more advanced form of PDSA, the DMAIC process. The DMAIC process breaks down into 5 sections; Define, Measure, Analyze, Improve, and Control. The approach is similar in approach to the PDSA, with the main difference being the inclusion of "control" to sustain successful changes after QIPs end. The TGA is committed to these models to improve the quality of care and services that result in better health outcomes.

In addition to sub-recipient progress reports on QIPs during the CQMC meetings, the TGA recipient staff conduct annual site visits during which improvement work is reviewed in more detail. The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the recipient conduct an annual site visit with each sub-recipient to ensure compliance on proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place. Appropriate quality improvement activities are a key part of the requirement.

During the annual site visit, the Quality Program Manager with the Grant Coordinator will meet with the sub-recipient quality lead to discuss progress and status of the QIP in a one-on-one format. The recipient staff will provide basic training in QI tools and other aspects of quality improvement if needed. Recipient staff will review status of the QIP and offer possible improvements suggestions when appropriate. If the sub-recipient identifies further need for one-on-one assistance during the annual site visit, the recipient will schedule additional technical assistance specific to the sub-recipients need. The recipient will also use the site visit to gather guidance for additional training opportunities that may be useful for the CQMC.

Participation of Stakeholders

As described in the Clinical Quality Management Committee Infrastructure section in this plan, the collaboration between internal and external stakeholders, and consumers, serves as the pathway to collect and share feedback from a variety of sources. Internal stakeholders are considered as those who are funded by Ryan White through the TGA. These stakeholders include a representative of each of the sub-recipient agencies who are charged with bringing information and updates on their patients to the CQMC forum.

External stakeholders are interested community partners who are not funded by the TGA. These stakeholders are critical as they can share information on the broad range of services they provide, alert the CQMC members to changes in their services or procedures, and offer training in how patients might access and benefit from their services. As the CQM Plan evolves and new priorities develop, additional external stakeholders may be invited to join the CQMC and contribute to the quality improvement process. External stakeholders are invited to participate in each CQMC meeting. During these meetings they may not only share information about their area of specialty, but they will also learn how they are contributing to the overall quality improvement process.

Consumer involvement is key to a successful effort to improve the health status of patients. Consumers currently attend the CQMC meetings and are engaged in providing feedback. As the CQMC members progress, discussions focusing on the provision of consumer trainings are held during the CQMC meetings. It is anticipated that guidance from HAB and CQII will be sought in building capacity for effective and impactful consumer engagement.

Evaluation

The CQMC acknowledges that the quality improvement plan is a very dynamic document. As new needs or challenges are discovered, shifts may occur in the CQMC membership, new priority measures may be added, established measures may be updated, or targeted populations may be redefined. The process of plan evaluation is ongoing and periodic adjustments may be made to address any emerging concerns.

During one quality committee meeting each year, an Organizational Assessment will be conducted by the committee participants to help evaluate the effectiveness of the activities implemented. The initial baseline assessment was completed in June 2016. The Program Manager leads the assessment, documents the scores, and makes them available for comparison on a yearly basis. If technical assistance from the Health Resources and Services Administration is requested and granted, HRSA would be available to lead the assessment for the committee. In addition, the following topics will be placed on the agenda to garner input and set direction:

- Has the committee used trended data to demonstrate progress towards goals?
- Has the committee been able to determine if specific quality improvement projects had resulted in improvements?
- Are the goals of the committee still appropriate, or do they need revision?
- Are there new/emerging priorities to address through our committee?
- Are we effectively communicating our findings to all internal and external stakeholders?

The discussions resulting from the Organizational Assessment and the questions above will help the committee evaluate their own effectiveness in promoting successful quality improvement activities. Findings from past evaluations will be included in future CQM Plans and work plans to allow for continuous learning.

Procedure for Updating the Clinical Quality Management Plan

The CQM Plan may be revised at any time during its implementation period. As the CQMC conducts the bi-annual evaluation, modifications to the plan may be identified and adjustments may be made. It is recognized that the CQM Plan should reflect any changes in priorities, and therefore may be amended to adopt a new or more appropriate direction at any time. However, a formal and complete update of the CQM Plan will occur every year.

Prior to the formal updating process, all committee members receive an electronic copy of the current CQM Plan for their own review. The members are encouraged to provide input and feedback on all relevant sections of the CQM Plan. The Quality Program Manager is tasked with learning where the committee would like to be 2 years into the future, and notes all desired revisions. The revisions are based on the progress made towards goals during the current CQM Plan period, and any new guidance provided by HRSA/HAB.

The work plan is a vital piece of the CQM Plan. As new goals and objectives are determined, the 2-year work plan is routinely updated to correspond to all activities set to occur during the duration of the new CQM Plan. The work plan construction is the responsibility of the Program Manager and the Grant Coordinator.

Upon initial completion of the new CQM Plan and work plan, a draft is circulated to all CQMC members for final review and approval. Subsequent to any additional modifications, the official adoption of the new CQM Plan occurs.

The intent of the CQM Plan updating procedure is to assure that quality improvement is a continuous process and that the committee members are visionary in establishing new goals and setting new directions.

Communication

Because of the great diversity in skill sets of CQMC members, effective communication is a priority. Internal stakeholders represent the clinical, social service, case management, data and information, and administrative areas of expertise. External stakeholders may or may not be well versed in HIV disease, but they will represent a wide array of community-based services. Consumers bring their perspective to the quality improvement process. Additionally, ongoing communication with the Planning Council is vital to a comprehensive approach to quality improvement.

The communication process consists of numerous pieces of information that are shared within the CQMC. These pieces of information help to inform all CQMC members and are shared at least quarterly through the routinely scheduled meetings.

- CQMC meeting agendas help to alert members to the expectations of the upcoming meeting.
- CQMC minutes are widely distributed and provide a history of events.
- QIP updates provided by the sub-recipients during the CQMC meetings are helpful to inform all members of the challenges and successes experienced by each agency.
- Successes are celebrated and shared with senior level management as a reminder of the significance of the quality improvement work performed by each agency.
- Trended data reports are the most critical piece of information, as they tell the story of progress. Data can be shared in a variety of ways to a variety of interested parties.
- The work plan is the piece of information that can help the CQMC stay on track and provide guidance and direction for ongoing work.

Any of the above pieces of communication may also be shared outside of the CQMC. Depending on the specific area of interest, certain information is reformatted to improve appeal and interest, and shared with:

- Senior level management within the TGA
- Senior level management at the sub-recipient agency
- HRSA/HAB during site visits or in response to a grant application
- The greater TGA community, local and regional newsletters, or relevant local, regional, or national conferences
- The Ohio statewide H4C cross-Part collaborative project

Appendix A

CQMC Member Guidelines

The following guidelines are designed to ensure that all CQMC meetings are conducted in a positive environment, are productive, open to community input, and respectful of all members and visitors. All CQMC members agree to:

1. Demonstrate trust to other participants.
2. Follow through on any commitments you make or assignments you accept.
3. Display professional courtesy during meetings and discussions with other participants.
    a. Listen to different points of view.
    b. Use respectful speaking
    c. Use respectful listening
    d. Make "I" not "You" statements
    e. Be Present
    f. Make your point and allow others to provide their input. No grandstanding.
    g. Ask for a literacy moment if you do not understand a concept or acronym.
    h. Be positive and constructive.
    i. Focus comments on the process, not the person.
4. Provide regular progress reports to the sponsors.
5. Consider cost-benefit aspects of our actions.
6. Keep sensitive information in the group.
7. Ask for help if you cannot complete assignments on time.
8. Do not let cell phones and laptops interrupt the process.
9. Have fun while making positive changes.

Appendix B

CQMC Member Roster

Representing:	Name:	Agency:
Part A Funded Agency	Brittany Pope	AIDS Healthcare Foundation
Part A Funded Agency	Joye Toombs	AIDS Taskforce
Part A Funded Agency	Adriana Whelan	Circle Health Services
Part A Funded Agency	Mary Beth Gramuglia	Cleveland Clinic
Part A Funded Agency	Sandrell Porter	DSAS
Part A Funded Agency	Jennifer Gosnell	Family Planning Services of Lorain
Part A Funded Agency	Kelly Dylag	Far West
Part A Funded Agency	Doug Vest	May Dugan
Part A Funded Agency	Summer Barnett	MercyHealth
Part A Funded Agency	Dr. Ann Avery	MetroHealth
Part A Funded Agency	Kim Rodas	Nueva Luz URC
Part A Funded Agency	Cathy Iannadrea	Signature Health
Part A Funded Agency	Dr. Barb Gripshover	University Hospitals
Ryan White Part B	Susan DiCocco	Ohio Department of Health
Ryan White Part C and D	Kate Burnett-Bruckman	University Hospitals of Cleveland
Planning Council - QI Representative	Jason McMinn	MetroHealth
Planning Council - Consumer Representative	Kimberlin Dennis	N/A
Planning Council - Consumer Representative	Robert Watkins	Recovery Resources
Mid-West AIDS Education Training Center	Jane Russell	Ohio State University
Community Agency	Fatima Warren	Circle Health Services
Community Agency	Ayme McCain	Recovery Resources
HIV Prevention Services & HOPWA	Persis Sosiak	Cleveland Dept. of Public Health

Appendix C

CQMC Work Plan

Activity	Objectives	Responsible Staff	Time Frame
CQMC meetings	Representation includes clinical and support services.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	January, April, July, October
	Agenda developed/ distributed one week prior to meeting.		
	Updated aggregate trended data presented at each meeting		
	Agencies present QIP updates at each meeting. Updates include challenges and successes, and any QIP modifications.		
	Minutes taken and distributed one week after meeting		
Data collection and performance measurement	Data reports for key TGA-wide QIPs are generated one month prior to CQMC meetings.	Grant Coordinator, Quality Program Manager	January, April, July, October
	Data are aggregated and reports prepared for distribution at CQMC meetings.		
	Data are trended and CQMC discussions link data trends to QIP progress.		
	Guided by data, CQMC members collaborate and brainstorm for strategy tweaks or new interventions	CQMC membership	
Capacity building	General QI trainings held during CQMC meetings: examples may include CQII tutorials, CQII coach webinars, local clinical expert presentations, HIV 101, PDSA 101, CBO service updates.	Quality Program Manager/invited experts	Minimum 2 per year, typically during webinars or agency site visit
	Targeted QI trainings conducted on site at the sub-recipient level when need is identified by recipient.	Grant Coordinator, Quality Program Manager	As needed basis
Site visits	Additional QI data abstracted from EMR/charts.	Grant Coordinator, Quality Program Manager	Annual(at monitoring)
	Sub-recipient progress towards goals assessed.		
	QI training needs assessed. If needed, plans for targeted trainings are drafted.		
	If deficiencies are noted, follow up visits are scheduled.		

Planning Council Communication	Quality Program Manager liaisons with Planning Council	Quality Program Manager and PC representative	10 meetings per year
	Planning Council member attends TGA CQM meetings and shares Planning Council priorities		October 2020
Quality Improvement Projects	TGA-wide QIP priorities determined. At least one clinical outcomes project and one support service or case management project underway TGA-wide at all times.	Sub-recipient representatives, Quality Program Manager, Quality Grant Coordinator	January 2020
	Review QIP priorities for long-term progress and continued relevance. Adjust or modify as needed.		April 2020
	Review QIP priorities for short-term progress during CQMC meetings.		October 2020
	Review QIPs for alignment with national directives such NHAS 2020, HAB priorities, and In Care Campaign. Consider adding/dropping/enhancing/stratifying measures and QIPs for ongoing work.		May 2020
Evaluation	Conduct annual Organizational Assessment.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	October 2020
	Use results to provide future direction and priorities.		
	Compare annual OA results.		
	Use trended data on outcome measure to depict degree of progress.		
Update CQM Plan	CQMC reviews pieces of CQM plan and identifies areas needing revision.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	April 2021
	Draft of revised CQM plan is circulated for review, input, and modifications		July 2021
	Final CQM plan is circulated for approval		October 2021

Appendix D

CQM Acronyms and Definitions

Acronym	Full Phrase
AETC	AIDS Education and Training Center
ASO	AIDS Service Organization
CBO	Community Based Organization
CCBH	Cuyahoga County Board of Health
CQM	Clinical Quality Management
CQMC	Clinical Quality Management Committee
EMR	Electronic Medical Record
HAB	HIV AIDS Bureau
HRSA	Health Resources and Services Administration
NHAS	National HIV AIDS Strategy
CQII	Center for Quality Improvement and Innovation
OAHS	Outpatient Ambulatory Health Services
PDSA	Plan-Do-Study-Act Cycle
QI	Quality Improvement
QM	Quality Management
QA	Quality Assurance
QIP	Quality Improvement Project
RSR	Ryan White HIV AIDS Services Report
RWHAP	Ryan White HIV/AIDS Program
TGA	Transitional Grant Area

Term	Full Definition
Antiretroviral Therapy (ART)	An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable level
CAREWare	A scalable software package provided by HRSA to its grantees and their funded providers that enables users to monitor services and report on HIV clinical and supportive care.
Core Medical Services	A set of essential, direct health care services provided to people with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Extension Act. In the Cleveland TGA, funded core medical services include: Early Intervention Services; Health Insurance Premium and Cost Sharing Assistance; Home and Community Health Services; Home Health Care; Local AIDS Pharmaceutical Assistance; Medical Case Management; Medical Nutrition Therapy; Mental Health Services; Oral Health Services; Outpatient Ambulatory Medical Care; and Outpatient Substance Abuse Services.
HIV Care Continuum	The HIV Care Continuum is the extent to which individuals living with HIV are engaged in care and fully benefiting from antiretroviral therapy in terms of full viral suppression.
Recipient	Direct recipient of federal funds to administer the Ryan White Part A program.
Support Services	A set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. In the Cleveland TGA, funded support services include: Case Management (non-medical); Emergency Financial Assistance; Food Bank / Home Delivered Meals; Legal Services; Medical Transportation Services; Outreach Services; Psychosocial Support Services; and Residential Substance Abuse Services.
Sub-Recipient	Contracted service providers that receive funds directly from the Part A Recipient.
Viral Load	The amount of virus present in an individual's blood. Tracking viral load is used to monitor therapy during chronic viral infections.
Viral Suppression	When the amount of HIV virus present in an individual's blood is below the level of detectability of the assay used (i.e. "undetectable"). Individuals whose viral load is detectable and less than or equal to 200 copies/mL are also considered to be "suppressed."

Appendix E

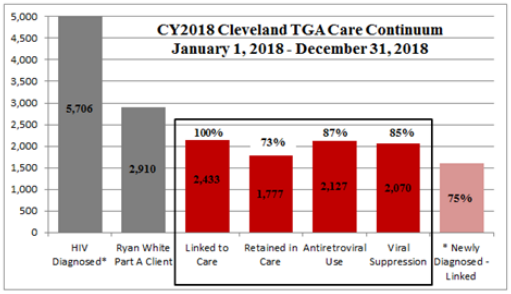
Cleveland TGA Treatment Cascade by Service Category

January 1, 2018 - December 31, 2018

Treatment Cascade Totals	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
	2,910	2,433	100%	1,777	73%	2,127	87%	2,070	85%	79	75%

Core Service Category	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
Outpatient Ambulatory Health Services (OAHS)	2,034	2,020	99%	1,588	79%	1,805	89%	1,745	86%	62	87%
Medical Case Management	1,076	884	82%	689	78%	821	93%	763	86%	19	58%
Early Intervention Services (EIS)	187	172	92%	96	56%	115	67%	111	65%	26	84%
Oral Health Care	303	266	88%	219	82%	241	91%	248	93%	1	50%
Mental Health Services	195	189	97%	147	78%	166	88%	162	86%	3	100%
Substance Abuse Outpatient Care	4	3	75%	3	100%	3	100%	2	67%	0	0%
Medical Nutrition Therapy	233	227	97%	203	89%	222	98%	215	95%	3	75%
Health Insurance Premium Cost Sharing Assistance (HIP	104	90	87%	71	79%	77	86%	85	94%	0	0%
Home/Community Based Health	35	24	69%	21	88%	24	100%	24	100%	0	0%
Home Health Care Services	37	26	70%	21	81%	26	100%	26	100%	0	0%

Support Service Category	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
Medical Transportation Services	1,308	1,083	83%	848	78%	939	87%	932	86%	37	76%
Emergency Financial Assistance (EFA)	44	42	95%	27	64%	29	69%	31	74%	3	100%
Food Bank / Home Delivered Meals	401	306	76%	224	73%	264	86%	252	82%	2	100%
Non-Medical Case Management Services	1,496	1,306	87%	957	73%	1,053	81%	1,064	81%	47	82%
Outreach Services	403	288	71%	157	55%	250	87%	209	73%	11	55%
Other Professional Services	243	183	75%	144	79%	161	88%	153	84%	4	80%
Psychosocial Support	123	109	89%	94	86%	95	87%	89	82%	4	80%
Substance Abuse Services - Residential	5	3	60%	2	67%	3	100%	3	100%	0	0%



- **HIV-Diagnosed:** Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health. *Please note: The most recent available prevalence data from the Ohio Department of Health is as of December 31, 2017.
- **Ryan White Part A Clients:** Number of diagnosed individuals who received a Ryan White Part A funded service in the measurement year.
- **Linked to Care:** Number of HIV positive individuals that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test in the measurement year.
- **Retained in Care:** Number of HIV positive individuals who had two or more Ryan White Part A funded medical visits, viral load or CD4 tests performed at least three months apart during the measurement year.
- **Antiretroviral Use:** Number of HIV positive individuals receiving Ryan White Part A funded medical care who have a documented antiretroviral therapy prescription on record in the measurement year.
- **Viral Suppression:** Number of HIV positive individuals receiving Ryan White Part A funded medical care whose most recent HIV viral load within the measurement year was less than 200 copies/mL.
- ***Newly Diagnosed - Linked:** Number of HIV positive individuals receiving a diagnosis of HIV in the measurement year that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test within ninety days of diagnosis. *Please note the denominator for Newly Diagnosed - Linked is different from the denominators used to calculate other steps in the continuum.

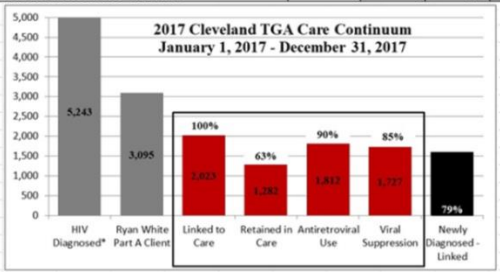
Cleveland TGA Treatment Cascade by Service Category - Draft Presented 2-21-18

January 1, 2017 - December 31, 2017

Treatment Cascade Totals	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
	3,095	2,023	100%	1,282	63%	1,812	90%	1,727	85%	62	79%

Core Service Category	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
Outpatient Ambulatory Health Services (OAHS)	2,023	2,023	100%	1,282	63%	1,812	90%	1,727	85%	62	79%
Medical Case Management	1,037	752	73%	512	68%	698	93%	562	75%	22	69%
Early Intervention Services (EIS)	205	139	68%	75	54%	92	66%	93	67%	32	86%
Oral Health Care	341	256	75%	194	76%	236	92%	210	82%	6	100%
Mental Health Services	308	252	82%	206	82%	220	87%	211	84%	5	63%
Substance Abuse Outpatient Care	40	34	85%	26	76%	32	94%	27	79%	1	100%
Medical Nutrition Therapy	275	242	88%	155	64%	183	76%	170	70%	7	88%
Health Insurance Premium Cost Sharing Assistance (HIPCSA)	84	71	85%	48	68%	62	87%	62	87%	1	50%
Home/Community Based Health	32	23	72%	13	57%	21	91%	20	87%	0	0%
Home Health Care Services	33	22	67%	12	55%	20	91%	20	91%	0	0%

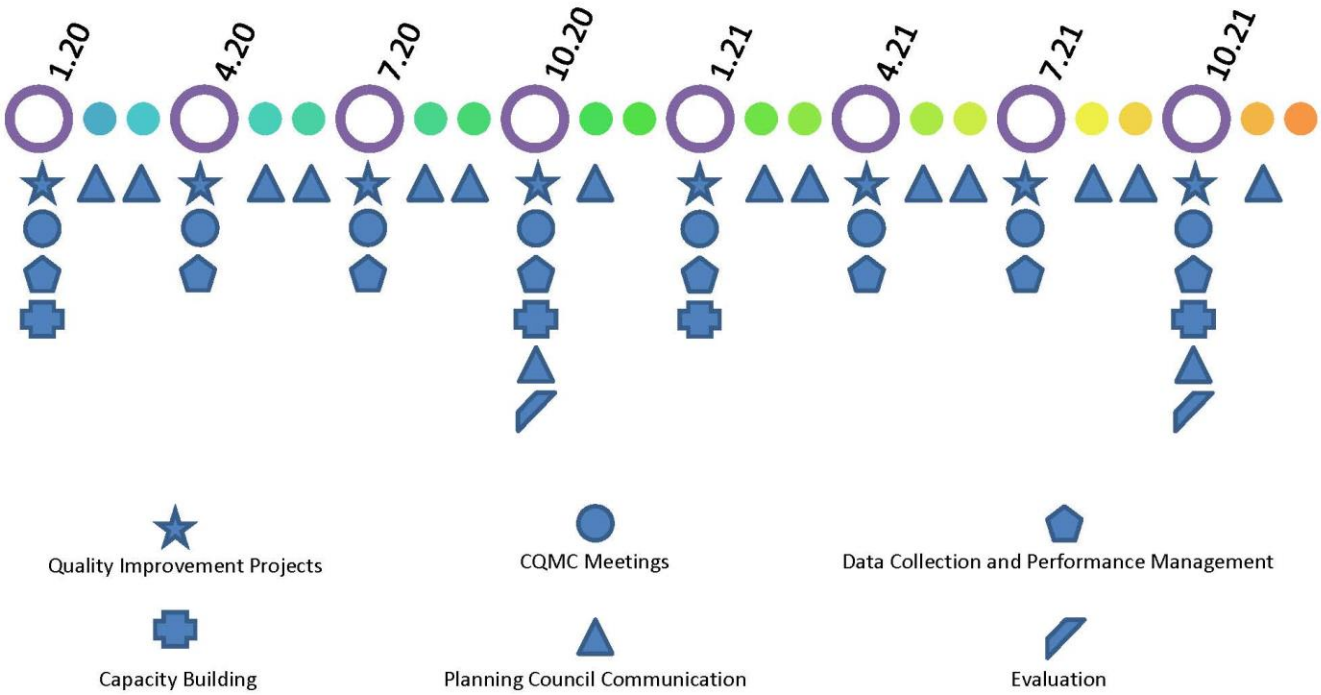
Support Service Category	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
Medical Transportation Services	1,470	1,006	68%	651	65%	922	92%	753	75%	29	64%
Emergency Financial Assistance (EFA)	75	56	75%	27	48%	39	70%	41	73%	6	67%
Food Bank / Home Delivered Meals	411	266	65%	124	47%	229	86%	223	84%	4	36%
Non-Medical Case Management Services	1,633	1,171	72%	659	56%	998	85%	811	69%	37	73%
Outreach Services	630	306	49%	149	49%	272	89%	195	64%	18	100%
Other Professional Services	226	138	61%	76	55%	123	89%	110	80%	3	50%
Psychosocial Support	109	84	77%	42	50%	67	80%	66	79%	5	83%
Substance Abuse Services - Residential	8	6	75%	1	17%	1	17%	1	17%	0	0%



- **HIV-Diagnosed:** Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health. *Please note: The most recent available prevalence data from the Ohio Department of Health is as of December 31, 2016.
- **Ryan White Part A Clients:** Number of diagnosed individuals who received a Ryan White Part A funded service in the measurement year.
- **Linked to Care:** Number of HIV positive individuals that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test in the measurement year.
- **Retained in Care:** Number of HIV positive individuals who had two or more Ryan White Part A funded medical visit, viral load test, or CD4 test performed at least three months apart during the measurement year.
- **Antiretroviral Use:** Number of HIV positive individuals receiving Ryan White Part A funded medical care who have a documented antiretroviral therapy prescription on record in the measurement year.
- **Viral Suppression:** Number of HIV positive individuals receiving Ryan White Part A funded medical care whose most recent HIV viral load within the measurement year was less than 200 copies/mL.
- ***Newly Diagnosed - Linked:** Number of HIV positive individuals receiving a diagnosis of HIV in the measurement year that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test within ninety days of diagnosis. *Please note the denominator for Newly Diagnosed - Linked is different from the denominators used to calculate other steps in the continuum.

Appendix F

CQMC Timeline



Annual Monitoring Site Visit Process - Ryan White Part A

Purpose of the Site Visit

The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the Ryan White Recipient conduct an annual site visits with each Sub-Recipient to ensure compliance on proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place.

Sub-Recipient Responsibility

- Providers are required to maintain an individual case record or medical record for each client served.
- All billed services match services documented in client records.
- All records are kept in a secure place and in an organized fashion and available at the start of the monitoring visit.
- Providers review and are familiar with service monitoring tools.
- Assembling and preparing all necessary records and materials for completion of the service monitoring tools by the Recipient.
- Have knowledgeable staff available to answer questions that may arise.
- Make available to the Recipient all materials listed in Attachment A and Attachment B.
- Submit to the Recipient Fiscal Policies within one week of receipt of electronic notification of site visit.
- Provide timely follow-up when identified from the Recipient.

Ryan White Recipient Responsibility Prior to the Visit

- Providers will be notified electronically no later than ten days prior to an on-site visit of the date(s) and time(s) of visit.
- The electronic notification will include **Attachment A – Fiscal Monitoring Site Visit Checklist, Attachment B – Program Monitoring and Site Visit Checklist.**
- The Recipient will review the previous year's fiscal, program and quality monitoring report and corrective action if applicable.
- No later than two (2) days before the monitoring site visit, the Recipient shall provide **Attachment C, Monitoring Site Visit Random Sample Form,** or the final list of records to be reviewed.

Ryan White Recipient Responsibility during the Site Visit

Conduct Opening Conference

- Upon arrival at the monitoring location, Recipient staff will meet with appropriate provider staff to discuss the purpose of the visit, review prior year monitoring outcomes, and address any questions the provider staff may have. The provider staff will be asked to explain how their charts or electronic medical records are organized so that data is accurately collected.

Perform Monitoring

- Recipient staff will review the requested charts and documents as outlined in the notification, using the monitoring tools. A random sample of client records is chosen for review as a means of verifying that services are being provided in accordance with established standards and recorded accurately. In order to ensure efficiency and accuracy of the monitoring process, appropriate provider staff must be available to Recipient staff when needed throughout the monitoring process.

Ryan White Recipient Responsibility Following the Site Visit

Recipient will send a formal written report of the site visit findings

- A formal written report summarizing the monitoring site visit, including findings and recommendations, will be sent to each provider within 30 days of the site visit.

Provide Technical Assistance

- Recipient staff will offer to provide technical assistance training on areas where deficiencies were noted.

Conduct additional site visits as necessary

- Recipient office reserves the right to conduct additional site visits as necessary to verify the implementation of any recommended quality improvement activities.
- Recipient staff will conduct a Follow-Up Site Visit when a provider receives a score of less than 69% on qualifying standards of the site visit report.
- Recipient staff will conduct a focused audit during any Follow-Up Site Visit within (6) six months following the adoption of a recommended Quality Improvement Plan.

Monitoring Performance Scale

QUALITY SCORE	QUALITY RATING	FOLLOW-UP ACTION
90 – 100%	**Excellent** Findings exceed quality expectations	No Action Required.
80 - 89%	**Effective** Findings meet quality expectations	No Action Required.
70 - 79%	**Moderate Deficiencies** Findings are below quality expectations	Written Corrective Action Plan required within 30 days of receipt of report.
69% and below	**Significant Deficiencies**	Probationary Period put in effect; Written Quality Improvement Plan required within 30 days; Services will be re-monitored until provider has addressed the finding and becomes compliant.

Significant Deficiencies Found during Visit

Quality Improvement and Corrective Action Plans

- When a programmatic site visit leads to the discovery of serious concerns about the quality of services that might negatively impact the health and safety of clients, Recipient staff will meet with the provider. The Recipient staff will provide a detailed overview of the concerns. This meeting will determine the appropriate manner in which the findings should be addressed and the appropriate sanction, if any, which should be imposed until the findings have been corrected.
- A Monitoring Performance Scale is used to determine when Quality Improvement Plans and Corrective Action Plans are necessary. Both plans address areas of deficiency, discuss changes that will be made to address deficiencies, and include a timeframe for implementation. Recipient staff will evaluate the provider's written response and notify the provider in writing of any findings to which the provider's response is not adequate. Depending on the severity of the deficiency, more than one monitoring visit during the grant cycle may be required.

- Any provider scoring between 70% and 79% on a qualifying standard will be required to submit a written Corrective Action Plan (CAP) to address the deficient areas within 30 days from the date of receipt of the monitoring report. The CAP must be implemented by the provider within 30 days of submission. The CAP will then be monitored during targeted trainings and technical assistance, as well as routine site visits. Any agency that does not achieve a satisfactory score of 80% on any standard will be subject to a re-monitoring site visit after 6 months. (see Page 4 for Sample Corrective Action Plan)
- Any provider receiving a quality score of 69% or below on a qualifying standard will require immediate follow-up. A written Quality Improvement Plan (QIP) will be required within 30 days of receipt of the monitoring report. The provider will have 30 days to implement the QIP from date of submission. The services will be re-monitored. Further action may be required if sub-recipient continues to have challenges.
- The "Plan-Do-Study-Act" (PDSA) quality improvement model will be used to initiate all quality improvement activities.

Random Sampling

The sample population is randomly selected from a pool of unduplicated Ryan White Part A clients who received services during the designated audit period. Please note that the random selection of unduplicated clients may change at the discretion of the Recipient staff. An **estimate** of sample sizes is listed below:

- 50-100% of files/charts for agencies with **20 Ryan White Part A clients or fewer**
- 25-50% of files/charts for agencies with **21 to 100 Ryan White Part A clients**
- 10-25% of files/charts for agencies with **101 to 500 Ryan White Part A clients**
- 3-10% of files/charts for agencies with **501 clients Ryan White Part A or more**

Please note, prior monitoring report outcomes may be considered and used to reduce the outlined sample size configurations listed above.

Additional Considerations

Newly Funded Sub-Recipients

- For newly funded Sub-Recipients in a grant year, the Recipient will conduct an orientation site visit within four months of commencement of services. This site visit is an opportunity for the Recipient staff to give an overview of the roles and responsibilities of the Recipient and Sub-Recipient.
- The orientation site visit will consist of a review of the monitoring tools, a review of the program, fiscal, and service delivery requirements.

Previously Funded Sub-Recipients

- Because services are monitored in the year following the service delivery, an agency may no longer be under contract but may be required to participate in an on-site monitoring visit. The process outlined above will still be in effect for those agencies, however, corrective action plans will only need to be submitted for agencies wishing to apply for funding in the future.

Sample Corrective Action Plan:

A Corrective Action Plan sample is listed below, the full version of the document in Word format is available on the CCBH website at: ***www.ccbh.net/ryan-white-provider-resources***

This form should be seen as only a sample; Sub-Recipients may choose to alter the form in any way to meet their own agency needs.

Finding: (Please include detailed description of audit finding)		
Corrective Action Plan: (Please detail the corrective action that will take place to fix the finding, including objectives, goals, and activities)		
Anticipated Completion Date:		
Person/Department Responsible:		
Position:	**Phone:**	**Email:**

FY2020 Ryan White Part A
Monitoring Site Visit Check List

Fiscal Monitoring

Please respond to each question separately and any documentation provided to support a response should be referenced with the respective question number.

1. How does your agency ensure reimbursement requests to CCBH don't include unallowable costs, direct or indirect, and that they conform to federal cost principles/Uniform Guidance? Provide policies and procedures to support your response.
2. Provide policy and/or process that guide the selection of an auditor.
3. Provide all financial policies and procedures including: billing and collection, purchasing and procurement, and accounts payable systems.
4. Does your agency receive program income? Provide policies and procedures regarding the handling of Ryan White revenues, including program income.
5. Provide allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources.
6. Provide property standards policy.
7. Provide a description of how Ryan White program staff is made aware of all required fiscal policies.
8. Provide a description of how fiscal staff is made aware of applicable federal regulations.
9. Does your agency establish a Medical Practice Management System for billing? If so, what is the name of the system? How it enables tracking of Ryan White program income separately from other income. Please explain. If the Medical Practice Management System can't perform this tracking, provide a description of how Ryan White program income is tracked.
10. Provide a description of how fiscal files are maintained and secured.

Please note, that unlike quality chart monitoring, fiscal monitoring is done for the current grant year in which you are delivering services. Please make sure that all policies and documents are your most current on file.

To view the full Ryan White Part A Cleveland TGA Fiscal Audit Tool please visit:
http://www.ccbh.net/ryan-white-provider-resources

FY2020 Ryan White Part A
Monitoring Site Visit Check List

Program Monitoring

Please have the following program information available on the first day of the site visit

1. Consumer Advisory Board membership list, meeting notices, and meeting minutes.
2. Client satisfaction survey tools, analysis and documented use of results.
3. Agency's Grievance Policy and Procedure
4. File of all Ryan White clients who were refused services, with the reason for refusal specified.
5. File of all formal client complaints received, grievances filed, and follow-up outcomes.
6. Copy of eligibility policies, including agency policies that do not permit denial of service due to pre-existing or present health conditions and that do not consider VA health benefits as primary health coverage for the purposes of Ryan White.
7. Documentation that all staff involved in eligibility determination are properly trained.
8. Informational materials about agency services, newsletters, and promotional materials.
9. Documentation of agency Corporate Compliance Plan in providing Medicare or Medicaid reimbursable services.
10. Agency personnel policy handbook and/or manual.
11. Agency code of ethics and conflict of interest policies.
12. Documentation of any employee or board member violations of Code of Ethics policy.
13. Progress report(s) on previously established corrective action plans or PDSA initiatives.
14. Documentation of established linkage agreements with key points of entry into the Ryan White system of care.
15. Documentation that a referral tracking system is in place for key points of entry into the Ryan White system of care.
16. Copies of staff resumes, certifications, and licensures where required. (please see Program Services Tool for details on requirements per service category)

Service category specific program requirements are outlined in the Program Services Tool. In addition to the items listed above, please make sure to review and prepare all service category requirements and have them available for review at the start of your scheduled visit.

http://www.ccbh.net/ryan-white-provider-resources